STATE OF SOUTH DAKOTA COUNTY OF MINNEHAHA	) :SS)	IN CIRCUIT COURT SECOND JUDICIAL DISTRICT

CHARLES RUSSELL RHINES, Plaintiff, vs. SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, SECRETARY, SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, and DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY. Defendants.	49CIV19-002940 **NOTICE OF APPEAL**

SUPREME COURT
STATE OF SOUTH DAKOTA
FILED
NOV - 1 2019
Clerk

TO: Jason R. Ravnsborg, Attorney General and Paul S. Swedlund, Assistant Attorney General, Attorneys for Defendants South Dakota Department of Corrections, Mike Leidholt, Secretary, South Dakota Department of Corrections, and Darin Young, Warden of the South Dakota State Penitentiary, 1302 East Highway 14, Suite 1, Pierre, SD 57501-8501:

NOTICE IS HEREBY GIVEN that the Plaintiff, Charles Russell Rhines, hereby appeals to the South Dakota Supreme Court the whole of the Order Denying an Application for a Temporary Restraining Order, Preliminary Injunction, and Stay of Execution in the above-entitled matter, which was signed by the Honorable Jon C. Sogn, Judge of the Second Judicial Circuit in and for Minnehaha County on October 31, 2019, with the Notice of Entry of the same being served on Plaintiffs of Courts on October 31, 2019, and from the whole of the record in this action.

Dated this 31st day of October, 2019.

BALLARD SPAHR LLP

By: _____

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FILED
OCT 31 2019
Minnehaha County, S.D.
Clerk Circuit Court

STATE OF SOUTH DAKOTA } ss
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on record in my office.
OCT 31 2019
Clerk of Courts, Minnehaha County
By _____ Deputy

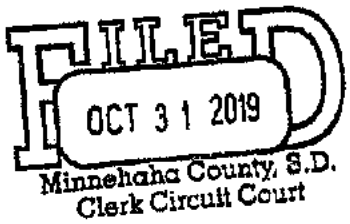
CERTIFICATE OF SERVICE

I, Daniel R. Fritz, hereby certify that on this 31st day of October, 2019, a true and correct copy of the foregoing ***Notice of Appeal*** in the above-entitled matter was provided via first class mail, postage prepaid, and via e-mail to the following named persons at their last known address:

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STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	:SS	
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

CHARLES RUSSELL RHINES, Plaintiff, vs. **SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, SECRETARY, SOUTH DAKOTA DEPARTMENT OF CORRECTIONS,** and **DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY,** Defendants.	49CIV19-002940 **MEMORANDUM OPINION AND ORDER DENYING APPLICATION FOR PRELIMINARY INJUNCTION AND STAY OF EXECUTION** SUPREME COURT STATE OF SOUTH DAKOTA FILED NOV - 1 2019 Clerk

Plaintiff Charles Rhines (Rhines) is scheduled to be executed by lethal injection sometime between November 3-9, 2019, for the murder of Donnivan Schaeffer. Rhines seeks a preliminary injunction and stay of the execution for such duration as necessary to have a full trial on the merits of his complaint alleging that the proposed drug the State intends to use in the lethal injection process, pentobarbital, is not an "ultra-short-acting" barbiturate as required by South Dakota statutes. The State opposes the request, asserting Rhines' claims are barred by res judicata and further that pentobarbital is an ultra-short acting barbiturate as that phrase is used in the statute. The matter came before the Court for hearing on October 29, 2019.

After considering the parties' written submissions, testimony presented at the hearing, the applicable authorities, the record, and oral arguments, the Court denies Rhines' request for a preliminary injunction and stay of execution.

FACTUAL BACKGROUND

On March 8, 1992, the body of Donnivan Schaeffer, an employee of Dig 'Em Donuts in Rapid City, South Dakota, was found in the storeroom of the donut shop. His hands were bound, and he had stab wounds to his abdomen, upper back, and the back of his neck. There was also money missing from the store.

After an investigation, Charles Rhines was charged with third-degree burglary of the store and first-degree murder of Mr. Schaeffer.

A jury trial was held, and on January 22, 1993, the jury found Rhines guilty of these crimes. The jury recommended a sentence of death for the first-degree murder conviction. The trial court entered a judgment and issued a warrant of execution.

Rhines appealed the conviction and sentence to the South Dakota Supreme Court. The South Dakota Supreme Court affirmed the conviction and sentence in an opinion that was issued May 15, 1996. *State v. Rhines, 1996* S.D. 55, 548 N.W.2d 415.

Since that time Rhines has pursued a multitude of suits and appeals, both in the South Dakota state court system, and in the federal court system, including a case in which a decision was issued October 25, 2019, by the South Dakota Supreme Court affirming the dismissal of Rhines' suit challenging a Department of Corrections administrative policy relating to the methods and procedures for carrying out capital

sentences. *Rhines v. South Dakota Department of Corrections*, 2019 S.D. 59, ___ N.W.2d ___.

Rhines is currently scheduled for execution sometime during the week of November 3-9, 2019.

Rhines' request for relief in this case arises out of the South Dakota Legislature's 2007 revisions to South Dakota's death penalty statutes contained in South Dakota Codified Laws Chapters 23A-27A. Prior to the 2007 changes, SDCL 23A-27A-32 read in applicable part:

> The punishment of death shall be inflicted by the intravenous administration of a lethal quantity of **an ultra-short-acting barbiturate** in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice. (*emphasis added*).

The 2007 revisions changed the statute to read in applicable part:

> The punishment of death shall be inflicted by the intravenous injection of a substance or substances in a lethal quantity. The warden, subject to the approval of the secretary of corrections, shall determine the substances and the quantity of substances used for the punishment of death.

At the same time SDCL 23A-27A-32 was revised in 2007, the legislature added a new section, 23A-27A-32.1, which states:

> Any person convicted of a capital offense or sentenced to death prior to July 1, 2007 may choose to be executed in a manner provided in § 23A-27A-32 or in the manner provided by South Dakota law at the time of the person's conviction or sentence. The person shall choose by indicating in writing to the warden not less than seven days prior to the scheduled week of execution the manner of execution chosen. If the person fails or refuses to choose in the time provided under this section, then the person shall be executed as provided in 23A-27A-32.

On October 1, 2019, pursuant to SDCL 23A-27A-32.1, Rhines submitted a "KITE-REQUEST SLIP" addressed to Warden Darin Young in which Rhines elected the method of execution that was in effect at the time that he was sentenced to death. On October 4, 2019, an amended "KITE-REQUEST SLIP" was submitted by Rhines, again addressed to Warden Young, in which Rhines elected the method of execution that was in effect at the time he was sentenced to death, clarifying that the chosen method was pursuant to the two-drug protocol of a lethal dose of an ultra-short-acting barbiturate and chemical paralytic.

On October 15, 2019, attorneys for Rhines sent a letter by e-mail to Warden Young and the Attorney General requesting confirmation that Rhines' requests to be executed by the intravenous administration of a lethal quantity of an ultra-short acting barbiturate would be honored. Rhines' attorneys also requested that the State identify which ultra-short-acting barbiturate would be used to execute Rhines.

Two days later, October 17, 2019, Assistant Attorney General Paul Swedlund, on behalf of the State, sent an e-mail to Rhines' attorneys, stating:

> I am in receipt of your letter regarding Mr. Rhines' request for execution pursuant to the combination of drugs provided by statute at the time of his execution. The DOC will follow the law. The ultra-short-acting barbiturate the State intends to use is pentobarbital.

Five days later, October 22, 2019, Rhines filed this suit against Defendants (hereinafter collectively referred to as the "State") challenging the State's use of pentobarbital. Rhines also filed his application for a preliminary injunction and stay of execution, his brief in support of his application, an affidavit by his attorney, Dan

Fritz, with documents attached being relied upon by Rhines, and an affidavit by Rhines' expert, Craig Stevens, Ph.D. An amended complaint was filed the next day, October 23, 2019.

Because the execution is scheduled for next week, an expedited hearing was held October 29, 2019. Prior to the hearing, the State submitted a brief opposing Rhines' requests. The State also submitted documents in support of their argument, including a Declaration of Joseph Antognini, M.D.

At the hearing, the parties presented their respective arguments. Rhines also called his expert, Craig Stevens, Ph.D as a witness. Because of the expedited schedule, the State's expert, Joseph Antognini, M.D., was not available to testify, but his affidavit had previously been submitted.

OVERVIEW

In this suit Rhines is not challenging whether he received a fair trial. He is not challenging his conviction for first-degree murder. He is not challenging his sentence of death by lethal injection. He is not challenging whether death by lethal injection violates the Eighth Amendment prohibition against cruel and unusual punishment. He is challenging whether pentobarbital is an ultra-short-acting barbiturate as that phrase was used in SDCL 23A-27A-32.

Barbiturates are a drug group derived from barbituric acid. Barbiturates depress the central nervous system and have long been used as sedatives and hypnotics. Depending on the type of barbiturate and the size of the dosage, the drug can be used to

reduce anxiety, help a person fall asleep, or to render a person unconscious. Depending on the type and the dose, it can also be lethal.

In the two-drug protocol followed by South Dakota in executing a death sentence by lethal injection, a large dose of the barbiturate is administered intravenously. This is intended to cause unconsciousness in less than a minute. After the prisoner is unconscious the prisoner is no longer aware of pain or distress. As the drug continues to affect the body, the respiratory system is suppressed, the brain is deprived of oxygen, and cardiac activity ceases. The barbiturate by itself is sufficient to cause death. To ensure death, however, after the prisoner is unconscious, a paralytic agent is administered intravenously. This further inhibits muscle action, including ceasing cardiac activity.

Rhines agrees this case does not involve a challenge to the paralytic agent the State intends to use, but only a challenge to the use of pentobarbital as the barbiturate the State intends to administer. In support of his challenge, Rhines retained Dr. Craig Stevens. Dr. Stevens has a Ph.D. in Pharmacology and is currently a Professor of Pharmacology at Oklahoma State University. Dr. Stevens submitted an affidavit and testified at the October 29, 2019, hearing. In his opinion, barbiturates are divided into four distinct categories: ultra-short acting, short-acting, intermediate-acting, and long-acting. In his affidavit he states the classifications refer to the time of onset and duration of the drugs' effects. He testified that, the faster the onset (time required for the drug to take effect), the shorter the duration (time it takes for the drug to wear off). During his testimony at the hearing, he added that the classifications also relate to the drugs' lipid solubility.

In Dr. Stevens' opinion, there are two "ultra-short-acting" barbiturates, sodium thiopental and methohexital. Thiopental, the most frequently used ultra-short-acting barbiturate, is used in short-duration surgeries. The onset of anesthesia is usually within 10 to 30 seconds, because thiopental is so lipid soluble that it rapidly enters the brain.

Dr. Stevens also opines that pentobarbital is classified as a short-acting barbiturate, not an ultra-short-acting barbiturate. In support of his opinion, Dr. Stevens references various publications that place pentobarbital in the class of fast-acting barbiturates. He noted that even the package insert for Nembutal Sodium Solution (a brand-name pentobarbital sodium injection) states it is a short-acting barbiturate.

Rhines also relies heavily on a Montana state court decision, *Smith v. State of Montana, Dept. of Corr.*, 2015 WL 5827252 (Mont. Dist. 2015). The trial judge in *Smith*, in interpreting a statute similar to SDCL 23A-27A-32, ruled that pentobarbital is not an ultra-fast-acting barbiturate and enjoined the state from using it in the state's lethal injection protocol. *Id.* It does not appear the *Smith* decision was appealed to the Montana Supreme Court.

The State's expert on this issue is Joseph Antognini, M.D. Dr. Antognini is board certified in anesthesiology and his experience includes being Director of Peri-operative Services at the University of California Davis Health; and a Professor of Anesthesiology and Pain Medicine and Professor of Neurobiology, Physiology, and Behavior at University of California, Davis.

In his Declaration, Dr. Antognini explains that barbiturates can be classified as "ultra-short acting", "ultra-fast acting", "short acting," and "fast acting." These

classifications, however, are not absolute and change depending on the size of the dosage of the drug and whether it is administered orally (a pill) or intravenously.

Importantly, Dr. Antognini explains that the terms "ultra-short acting" and "short-acting" refer to the duration of action of the drug, that is, the length of time the drug has its intended effect (i.e., how long it takes to wear off). Dr. Antognini further explains that "ultra-fast acting" and "fast-acting" refers to the onset of action, in other words the length of time it takes for the effect of the drug to occur.

Exhibit C attached to Dr. Antognini's Declaration shows that a clinical intravenous dosage of thiopental takes effect in 10-40 seconds, while a clinical dosage of pentobarbital takes effect in one minute. In lethal execution dosages, however, while thiopental intravenously still takes effect in 10-40 seconds, pentobarbital takes effect in 20-30 seconds. Accordingly, in lethal execution dosages, pentobarbital's onset may take effect more quickly than thiopental.

In Dr. Antognini's opinion, pentobarbital administered intravenously in the lethal dose the State intends to use in Rhines' execution, will cause Rhines to be unconscious within 20-30 seconds after the initiation of the infusion. This is consistent with the time it would take for Rhines to be unconscious after initiation of an infusion of thiopental (10-40 seconds). Accordingly, pentobarbital is consistent with the classification of an ultra-fast acting/ultra-short acting barbiturate.

Further, in lethal doses, the duration of the drug, whether pentobarbital or thiopental, is meaningless as the inmate will die prior to the time the drug's effects cease. The State argues that it makes no sense and would lead to an absurd result to think that

the legislature was requiring use of a drug, the effects of which would wear off quickly (a drug with a short duration). The drug must be of such duration that its effects extend beyond the time of death. Instead, the State asserts it does make sense that the legislature was referring to a drug that induces a very quick transition from consciousness to unconsciousness. In a lethal intravenous dosage, the transition from consciousness to unconsciousness is virtually the same whether it is thiopental or pentobarbital, and, in fact, may be faster with pentobarbital.

PRELIMINARY INJUNCTION STANDARDS

SDCL 15-6-65 and SDCL Chapter 21-8 confirm that courts have the authority to issue preliminary and permanent injunctions. Whether a preliminary injunction should be issued involves the consideration of four factors, namely: (1) the threat of irreparable harm to the movant; (2) the balance of equities between the parties; (3) the probability that the movant will succeed on the merits; and (4) the public interest. *Dataphase Systems, Inc. v. CL Systems, Inc.*, 640 F.2d 109, 113 (8th Cir. 1981) (en banc); *Hedlund v. River Bluff Estates, LLC*, 2018 S.D. 20, ¶ 15, 908 N.W.2d 766, 771; *Dacy v. Gors*, 471 N.W.2d 576, 579 (S.D. 1991). No single factor is determinative in deciding whether to issue a preliminary injunction. *Dataphase*, 640 F.2d at 113.

Irreparable Harm to the Movant

Death, of course, cannot be undone. Rhines, however, is not asserting in this suit that he should not be put to death by lethal injection. Instead, he asserts that the irreparable harm he will suffer is being deprived of his right to be executed in the manner provided for by South Dakota law, more specifically by the administration of lethal doses

of an ultra-short-acting barbiturate in combination with a paralytic agent. Rhines asserts the only barbiturates that qualify as ultra-short-acting barbiturates are thiopental and methohexital.

The State counters that there is no irreparable harm to Rhines because in lethal doses pentobarbital is an ultra-short-acting barbiturate as that phrase is used in SDCL 23A-27A-32. Further, the effect of pentobarbital in lethal doses is not materially different from the effect of thiopental, and in some circumstances, pentobarbital induces unconsciousness faster than thiopental.

In considering this factor, I find it is neutral, not favoring Rhines or the State.

Balance of Equities Between the Parties

Rhines asserts the harm to the State is a minimal incremental delay and the administrative inconvenience of seeking another execution warrant. Rhines further cites to *Bucklew v. Precythe*, 139 S.Ct. 1112, 1146 (2019), for the proposition that "the equities in a death penalty case will almost always favor the prisoner so long as he or she can show a reasonable probability of success on the merits."

The State counters with its own quote from *Bucklew*, that stays of execution "should be the extreme exception, not the norm." *Bucklew*, 139 S.Ct. at 1134. The State has a strong interest in enforcing its criminal judgments. *Hill v. McDonough*, 547 U.S. 573, 584 (2006). In addition, victims of crime (in this case the family of Donnivan Schaeffer) "have an important interest in the timely enforcement of a sentence." *Id.*

As stated in *Nelson v. Campbell*, 541 U.S. 637, 650 (2004), "[g]iven the state's significant interest in enforcing its criminal judgments, there is a strong equitable

presumption against the grant of a stay where a claim could have been brought at such a time as to allow consideration of the merits without requiring entry of a stay."

In *Ledford v. Comm'r, Georgia Dep't of Corr.*, 856 F.3d 1312, 1319-20 (11th Cir. 2017), the court denied a stay even though the inmate's claims were not necessarily barred by the statute of limitations. The court reasoned that the inmate had not been timely in waiting until five days before his execution to raise his claim. *Id.*

In *Jones v. Allen*, 485 F.3d 635 (11th Cir. 2007) an inmate facing imminent execution filed a last-minute challenge to Alabama's execution protocol, which had been adopted four years earlier. The Allen court concluded that the inmate's delay "leaves little doubt that the real purpose behind his claim is to seek a delay of his execution, not merely to effect an alteration of the manner in which it is carried out." *Jones*, 485 F.3d at 640.

In considering the equities in this matter, it is highly doubtful that the real purpose of this suit is Rhines' desire to die by the use of thiopental instead of pentobarbital as the barbiturate used in the two-drug protocol. Instead, the real purpose behind his claim is likely to seek a delay of his execution.

I find that the balance of equities between the parties favors the State.

Public Interest

The public interests in this matter are similar to the balance of equities between the parties, with the additional factor of the public's interest in its citizens and public officials complying with the laws passed by our legislature. The public has a strong interest in making sure the State complies with laws passed by our legislature. This interest is

magnified when the State is carrying out the ultimate criminal penalty—death. Whether this factor favors the State or Rhines, however, depends in large part on this court's findings on the probability of Rhines being successful on the merits of his challenge.

Probability that Movant Will Succeed on the Merits

In this case, the most significant factor in determining whether to grant Rhines' request for an injunction and stay of execution is the probability of Rhines succeeding on the merits of his claim. As stated in Hill, this requires Rhines to show "a significant possibility of success on the merits." *Hill*, 547 U.S. at 584. To determine this, the court must first address the issue of whether Rhines' suit is barred by the doctrine of res judicata.

Res Judicata

The State argues that Rhines' current claims are barred by res judicata. It argues that Rhines could have and should have raised this challenge eight years ago rather than waiting until less than two weeks before his execution is scheduled. The federal courts have held

> "A court considering a stay must ... apply 'a strong equitable presumption against the grant of a stay where a claim could have been brought at such a time as to allow consideration of the merits without requiring entry of a stay.'" *Hill v. McDonough*, 547 U.S. 573, 584, 126 S.Ct. 2096, 165 L.Ed.2d 44 (2006) (quoting *Nelson v. Campbell*, 541 U.S. 637, 650, 124 S.Ct. 2117, 158 L.Ed.2d 924 (2004)).

McGehee v. Hutchinson, 854 F.3d 488, 491 (8th Cir.), *cert. denied*, 137 S. Ct. 1275, 197 (2017).

The 2007 additions to SDCL 23A-27A-32 allow the warden to determine the substances and quantity of substances used for the punishment of death. In 2008, Rhines

amended his pending habeas petition in Pennington County (51 CIV 02-924) to also include a complaint for declaratory and injunctive relief. The declaratory and injunctive relief sought was in response to the statutory language in 23A-27A-32. Rhines' requested relief included: (1) a declaration that an execution carried out by means of the two drug cocktail provided in SDCL 23A-27A-32 in effect at the time of his conviction constitutes cruel and unusual punishment in violation of the South Dakota and United States Constitutions, as well as deprives him of his right to due process of law, and is therefore unconstitutional; and (2) a declaration that SDCL 23A-27A-32, as presently codified, and as applied to Rhines, constitutes an unconstitutional bill of attainder and an unconstitutional ex post facto law and deprives him of his right to due process of the law.

In August 2010, following the changes in 2007 to the statute and the United States Supreme Court decision in *Baze v. Rees,* 553 U.S. 35, the State revised its existing execution policy and protocol ("the protocol"). The protocol used the same three-drug protocol approved in *Baze.* In response to emerging judicial acceptance of pentobarbital as an execution anesthetic, the State again modified the protocol in October of 2011 to also provide for execution via a 1-drug, pentobarbital protocol for all prospective executions. After the adoption of the revised protocol, Rhines was served with notice of the protocol on October 21, 2011. Exhibit 1 attached to the State's brief in this matter is the notice and protocol.

The protocol included a policy on the substances and quantity of substances to be used for executions. The protocol identified the contents of the syringes for 3-Drug, 2-Drug, and 1-Drug executions. With regard to the barbiturates used for executions, the

protocol identified that either sodium thiopental *or* pentobarbital would be used. Importantly, following the charts describing the drugs to be utilized in executions, paragraph 4 on page 3 stated:

> Any person sentenced to death prior to July 1, 2007, may choose to be executed by the 3- or 1-Drug protocol set forth in this document, provided the SDDOC possess the necessary substance or substances for the method chosen at the time scheduled for the inmate's execution, or in the manner provided by South Dakota law at the time of the person's conviction *(2-Drug protocol set forth in this document).*[1]

After notice of the protocol in October of 2011, Petitioner made no further amendments to his petition. A court trial was held over a year later in December of 2012. During this period, discovery ensued and experts were deposed. Experts were deposed largely on the subject of a 3-drug protocol and whether it violates the Eighth Amendment; however, pentobarbital was a subject of frequent questioning. On February 27, 2013, Judge Trimble issued an Order denying Petitioner's claims, which decision included discussions of the use of pentobarbital. Both the circuit court and the South Dakota Supreme Court denied a Certificate of Probable Cause.

"Res judicata precludes relitigation of issues previously heard and resolved; it also bars prosecution of claims that *could have been raised in the earlier proceeding*, even though not actually raised." *Hobart v. Ferebee*, 2009 S.D. 101, ¶ 30, 776 N.W.2d 67, 76 (emphasis added). The South Dakota Supreme Court has also advised that:

> Res judicata consists of two preclusion concepts: issue preclusion and claim preclusion." *Am. Family Ins. Grp. v. Robnik*, 2010 S.D. 69, ¶ 15, 787 N.W.2d

[1] Exhibit 1 attached to State's brief in this matter.

> 768, 774. "Issue preclusion refers to the effect of a judgment in foreclosing relitigation of a matter that has been litigated and decided," and "also is referred to as direct or collateral estoppel." *Id.* (quoting *Migra v. Warren City Sch. Dist. Bd. of Educ.*, 465 U.S. 75, 77 n.1, 104 S.Ct. 892, 894 n.1, 79 L.Ed.2d 56). "Claim preclusion refers to the effect of a judgment in foreclosing litigation of a matter that never has been litigated, because of a determination that it should have been advanced in an earlier suit...." Id (quoting *Migra*, 465 U.S. at 77 n.1, 104 S.Ct. at 894 n.1). "To invoke the doctrine of res judicata, four elements must be established: (1) a final judgment on the merits in an earlier action; (2) the question decided in the former action is the same as the one decided in the present action; (3) the parties are the same; and (4) there was a full and fair opportunity to litigate the issues in the prior proceeding. *People ex rel. L.S.*, 2006 S.D. 76, ¶ 22, 721 N.W.2d 83, 89–90.

Estate of Johnson ex rel Johnson v. Weber, 2017 S.D. 36, ¶ 41, 898 N.W.2d 718, 733, reh'g denied (July 28, 2017).

When examining a res judicata argument, a court is "not restricted to whether the specific question posed by the parties in both actions was the same or whether the legal question posed by the nature of the suit was the same." *Farmer v. S. Dakota Dep't of Revenue & Regulation*, 2010 S.D. 35, ¶ 10, 781 N.W.2d 655, 660. Instead, "[a] cause of action is comprised of the facts which give rise to, or establish, the right a party seeks to enforce." *Merchants State Bank v. Light*, 458 N.W.2d 792, 794 (citing *Bank of Hoven v. Rausch*, 449 N.W.2d 263, 266)). "Essentially, it is the underlying facts which give rise to the cause of action that must determine the propriety or necessity of presenting a specific issue within the prior proceedings." *Lewton v. McCauley*, 460 N.W.2d 728, 731 (S.D. 1990).

This Court considers the cases of *Lewton* and *Farmer* as instructive in understanding res judicata. In both cases, each claim arose out of factually similar

scenarios. In *Farmer,* both claims arose out of the same act: failure to pay taxes. Because both claims came from the same transaction and one already had a final judgment, the Court found that res judicata applied. Similarly, in *Lewton*, both claims arose out of the same scenario: Lewton's bankruptcy. However, the difference in *Lewton* focuses on whether the subsequent claim even existed at the time the first claim was brought. While the first claim concerned the cattle and the contract between the parties, the amount of rent owed is certainly related to both; however, the second claim could not have been brought at that time because the issue of the amount of rent owed derived from the first court's decision. *Lewton* demonstrates that while the two claims may arise out of the same factual scenario, the second claim must have existed at the time if a party is going to assert that the claim should have been brought pursuant to the doctrine of res judicata. *Farmer*, on the other hand, demonstrates two separate claims related to the same action. If the party had a fair opportunity to litigate the second claim during the proceedings of the first claim, res judicata precludes the subsequent action.

Rhines had a full and fair opportunity to challenge the protocol's compliance with the statutes in his 2011 Pennington County action. Rhines was put on notice of the State's intent to use pentobarbital when Rhines was served with a copy of the protocol on October 24, 2011. The protocol contained explicit notice of the State's intention to use pentobarbital in the 2-drug protocol that Rhines ultimately elected. Rhine's then-pending complaint for declaratory and injunctive relief contained general arguments that the protocol denied him due process that he felt he was entitled to under SDCL 23A-27A-32 and opposed the "two chemicals" that would be used. Experts in the case frequently

discussed the use of pentobarbital in the execution. In a deposition taken December 1, 2012, one of Rhine's own experts, Dr. Mark Heath, testified at length about the use of pentobarbital. A copy of Dr. Heath's deposition is attached as Exhibit 8 to the State's brief in this case. Examples of Dr. Heath's discussion of pentobarbital includes testimony on page 21 of the deposition transcript that "pentobarbital is typically put into the short or medium-acting categories." Further on page 22 he discusses the differences between thiopental and pentobarbital. On page 22 he is asked whether he has "reviewed the protocol and have an understanding at least a paper level of how the State of South Dakota intends to use pentobarbital as a lethal injection drug", to which Dr. Heath replies "Yes."

Additionally, during the litigation of Rhine's method of execution claims, the State had an expert opine on whether a 2-drug protocol of pentobarbital and a paralytic agent would provide a painless and humane death for an inmate. Therefore, not only was Rhines put on notice in October of 2011, but he was also put on notice, through the deposition of the experts, of the State's intent to use pentobarbital in carrying out the 2-drug protocol.

Because Rhines was aware of the State's intent to use pentobarbital in its 2-drug protocol, Rhines could have and should have brought a specific challenge to the use of pentobarbital as part of his then-pending complaint for declaratory and injunctive relief eight years ago. While Rhines challenged many other aspects with regard to 23A-27A-32, Rhines failed to present any argument as to pentobarbital when the protocol explicitly listed pentobarbital as one of two drugs that could be administered in the 2-drug protocol.

Because the declaratory action sought in the prior litigation specifically talked about both drugs, the protocol, and the statute, Rhines was bound to bring the claims at that time, not eight years later and just days before his scheduled execution.

The State further asserts that this was a strategic attempt to stay his execution because he also could have asserted the claims in his APA challenge in August of 2018 but did not do so. *See Rhines v. South Dakota Dept. of Corrections*, 2019 S.D. 59, __ N.W.2d __.

At the hearing, Rhines asserted that the claims are not barred by res judicata because the claim was not ripe until the State's non-compliance with the statute. Rhines also argues that the claims asserted are not the same under a res judicata analysis. As to the ripeness, Rhines argues that SDCL 23A-27A-32.1 provides him with a right to elect which method of execution to administer up until 7 days prior to the scheduled week of execution. Thus, the choice to elect which method of execution gives him authority to wait to choose his manner of execution and no issue existed until the State notified him that the barbiturate to be used at his execution would be pentobarbital.

This court finds that argument unpersuasive. As discussed above, Rhines initially filed a habeas petition on unrelated grounds in Pennington County in 2002. Following the amendments to the statutes in 2007, Rhines amended his petition in 2008 seeking declaratory and injunctive relief based on the constitutionality of SDCL 23A-27A-32 before and after the amendments. Many of Rhines' claims related to the changes in the statutes and the lack of specificity of what kind of drugs would be utilized in an execution. The protocol was issued in 2010 and revised in 2011 and provided specific

explanations of the types of drugs the State would utilize, among others. Further, the protocol in paragraph 4 on page 3 made it clear that the 2-drug protocol was exclusively applied to inmates sentenced prior to 2007, such as Rhines. Rhines was put on notice of the adoption and revision of the protocol. The protocol specifically referenced pentobarbital as one of two barbiturates to be used in a 3-, 2-, or 1- drug execution. Rhines had this information and made no amendments to his current declaratory and injunctive requests in his petition. Unlike *Lewton*, Rhines' cause of action existed at the time his Pennington County declaratory judgment action was pending. Rhines had a "full and fair opportunity to litigate" the validity of whether the protocol was in compliance with the language under SDCL 23A-27A-32 at that time.

As to Rhines' ripeness argument, SDCL 21-24-1 permits the declaration of legal rights or relations before an actual injury occurs.[2] When seeking declaratory relief, there are four jurisdictional requirements that must be established:

> (1) There must exist a justiciable controversy; that is to say, a controversy in which a claim of right is asserted against one who has an interest in contesting it; (2) the controversy must be between persons whose interests are adverse; (3) the party seeking declaratory relief must have a legal interest in the controversy, that is to say, a legally protectible interest; and (4) the issue involved in the controversy must be ripe for judicial determination.

Boever v. South Dakota Bd. Of Accountancy, 526 N.W.2d 747, 750 (quoting *Danforth v. City of Yankton*, 25 N.W.2d 50, 53 (S.D. 1946). "Ripeness involves the timing of judicial

[2] SDCL 21-24-1 provides: Courts of record within their respective jurisdictions shall have power to declare rights, status, and other legal relations whether or not further relief is or could be claimed. No action or proceeding shall be open to objection on the ground that a declaratory judgment or decree is prayed for. The declaration may be either affirmative or negative in form and effect; and such declaration shall have the force and effect of a final judgment or decree.

review and the principle that '[j]udicial machinery should be conserved for problems which are real and present or imminent, not squandered on problems which are abstract or hypothetical or remote.'" *Id.* (quoting *Gottschalk v. Hegg*, 228 N.W.2d 640, 643–44 (S.D.1975) (quoting Davis, *Administrative Law Treatise*, § 21.01)).

In *Boever v. South Dakota Bd. of Accountancy*, Boever was a certified public accountant licensed under SDCL ch 36-20A. 526 N.W.2d 747, 748 (S.D. 1995). In order to maintain his licensure, Boever, as well as all CPAs, were subjected to quality reviews every three years pursuant to statute. *Id.* After a statutorily mandated quality review was conducted, the South Dakota Department of Legislative Audit filed a complaint against Boever. *Id.* at 749. In an agreement to terminate disciplinary action against Boever, he agreed to undergo another quality review. *Id.* Shortly after his agreement, Boever filed a complaint in circuit court seeking a declaration at the review and disciplinary statutes were unconstitutional due to vagueness and lack of sufficient standards to constitute a lawful delegation of legislative powers. *Id.* The trial court found that the claims were not ripe because there was "no present controversy." *Id.*

On appeal, the South Dakota Supreme Court affirmed and reversed in part. *Id.* at 751. In the analysis, the Court affirmed the trial court's conclusion that there was no present controversy with regard to the disciplinary statutes. *Id.* at 750. With regard to the quality review statutes, though, the Court reversed and remanded the trial court's decision based on the statutory language that required quality reviews every three years. *Id.* The language there provides for future quality reviews that are "imminent and

inevitable" because a review was bound to happen in the future. *Id.* The court therefore found that the constitutional challenge to the statute was ripe for review. *Id.*

Rhines was lawfully sentenced to death. Like the quality reviews statutes in *Boever*, Rhines execution was "imminent and inevitable." The statutes and protocol undoubtedly applied to Rhines in 2011 as much as it does now in 2019. The issue was ripe in 2011 when the protocol was issued because the protocol explicitly referenced pentobarbital as one of two barbiturates to be used in executions. Further, in his previous litigation in 2011, Rhines specifically referenced both drugs listed in the protocol in his declaratory action. Furthermore, in 2011, when the protocol was issued, the issue now presented was not abstract, hypothetical, or remote at that time.

The State is correct in its assertion that Rhines challenged the exact protocol in 2011 as he is challenging now. The protocol clearly indicated that the State would administer a barbiturate of either sodium thiopental or pentobarbital. Rhines places emphasis on the word *or* and argues that because he did not know which drug the State would use at his execution, the issue was not ripe. However, Rhines argument fails because the issue of the constitutionality of the 3-drug protocol was ripe for judicial review as was demonstrated by the Rhines' declaratory and injunctive action in 2011. Applying Rhines' logic, because the State or Rhines could have elected alternate methods of execution, his original claims in 2011 would also not have been ripe for adjudication. Therefore, the question of whether pentobarbital, as listed in the protocol and discussed in the habeas petition, fits within the statutory definition of an ultra-short acting barbiturate would be ripe as well.

The Eighth Circuit's decision in *McGehee v. Hutchinson*, in another death penalty case challenging the drug cocktails, also supports this court's decision. "Whether or not the claim technically is barred by doctrine of res judicata or collateral estoppel, the prisoners' use of "piecemeal litigation" and dilatory tactics is sufficient reason by itself to deny a stay." *McGehee v. Hutchinson*, 854 F.3d 488, 492-92 (8th Cir.), *cert. denied*, 137 S. Ct. 1275, 197 L.Ed. 2d 746 (2017) (quoting *Hill v. McDonough*, 547 U.S. at 584-85, 126 S.Ct. 2096). "Both the State and the victims of crime have an important interest in the timely enforcement of a sentence." *Hill v. McDonough*, 547 U.S. 573, 584, 126 S. Ct. 2096, 2104, 165 L. Ed. 2d 44 (2006) (quoting *Calderon v. Thompson*, 523 U.S. 538, 556, 118 S.Ct. 1489, 140 L.Ed.2d 728 (1998)).

The Court finds there is a strong probability that Rhines' claims are barred by res judicata, and further finds there is not a significant possibility that Rhines will be successful on the merits of the res judicata issue. Because of the court's finding on the res judicata issue, it does not need to, and does not, make a finding regarding whether pentobarbital is an ultra-short acting barbiturate as that phrase is used in SDCL 23A-27A-32.

ORDER

Based upon the foregoing, Rhines' request for a temporary restraining order and preliminary injunction is denied. Rhines' request for a stay of execution is also denied.

Dated this 31st day of October, 2019.

BY THE COURT:

Jon C. Sogn
Circuit Court Judge

ATTEST:
Angelia M. Gries, Clerk of Court
By: _____
Deputy Clerk

FILED
OCT 31 2019
Minnehaha County, S.D.
Clerk Circuit Court

STATE OF SOUTH DAKOTA	) :SS	IN CIRCUIT COURT
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL DISTRICT

CHARLES RUSSELL RHINES, Plaintiff, v. SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, SECRETARY, SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, and DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY, Defendant	49CIV19-002940 **THIS IS A CAPITAL CASE EXECUTION SET FOR BETWEEN NOVEMBER 3, 2019 AND NOVEMBER 9, 2019**

SUPREME COURT
STATE OF SOUTH DAKOTA
FILED
NOV - 1 2019
Clerk

NOTICE OF ENTRY OF ORDER

Plaintiff, Charles Russell Rhines through his counsel, Daniel R. Fritz, hereby serve notice of entry of the attached order in the above-captioned matter denying Plaintiffs' Application for Preliminary Injunction and Stay of Execution. Counsel certifies that on the date below he served a true and correct certified copy of the order on Paul S. Swedlund via e-mail to paul.swedlund@state.sd.us and by first class U.S. Mail to 1302 East Highway 14, Suite 1, Pierre, SD 57501.

Dated this 1st day of November, 2019.

BALLARD SPAHR LLP

By: /s/ Daniel R. Fritz

Daniel R. Fritz (2390)
Timothy R. Rahn (4871)
101 South Reid Street, Suite 302
Sioux Falls, SD 57103
Telephone: (605) 978-5200

Email: fritzd@ballardspahr.com
rahnt@ballardspahr.com

IN THE SUPREME COURT
STATE OF SOUTH DAKOTA

CHARLES RUSSELL RHINES, Plaintiffs vs. SOUTH DAKOTA DEPARTMENT OF CORRECTIONS and MIKE LEIDHOLT, Secretary, South Dakota Department of Corrections, and DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY, Defendants.	App. No. 49CIV19 2940 **APPELLANT'S DOCKETING STATEMENT** SUPREME COURT STATE OF SOUTH DAKOTA FILED NOV - 1 2019 Shirley A Jameson-Legg Clerk

Charles Russell Rhines, by and through his counsel of record, hereby submit Appellants' Docketing Statement as follows:

Section A.

TRIAL COURT

1. The circuit court from which the appeal is taken: **Second Judicial Circuit.**

2. The county in which the action is venued at the time of the appeal: **Minnehaha County.**

3. The name of the trial judge who entered the decision appealed: **The Honorable Jon C. Sogn.**

PARTIES AND ATTORNEYS

4. Identify each party presently of record and the name, address, and phone number of the attorney for each party:

Charles Russell Rhines

Daniel R. Fritz (2390)
Timothy R. Rahn (4871)
Ballard Spahr LLP
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(605) 978-5205

Caroline Heller
Greenberg Traurig, LLP
200 Park Avenue
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(212) 801-2165

South Dakota Department of Corrections and Mike Leidholt, Secretary, South Dakota Department of Corrections

Paul S. Swedlund
Assistant Attorney General
1302 East Highway 14, Suite 1
Pierre, South Dakota 57501-8501
Telephone: 605-773-3215
Paul.swedlund@state.sd.us

Section B.

TIMELINESS OF APPEAL

1. The date the judgment or order appeal from was signed and filed by the trial court: **Signed and filed on October 31, 2019.**

2. The date notice of entry of the judgment or order was served on each party: **October 31, 2019.**

3. State whether either of the following motions was made:

   a. Motion for judgment n.o.v., SDCL 15-6-50(b): _____Yes __X__No

   b. Motion for new trial, SDCL 15-6-59: _____Yes __X__No

NATURE AND DISPOSITION OF CLAIMS

4. State the nature of each party's separate claims, counterclaims or cross-claims and the trial court's disposition of each claim (e.g., court trial, jury verdict, summary judgment, default judgment, agency decision, affirmed/reversed, etc.).

On October 22, 2019, Rhines filed an action in the Circuit Court for the Second Judicial Circuit seeking injunctive and declaratory relief to enforce his statutory right under South Dakota law to be executed by the manner he chose. Rhines's Complaint alleges four causes of action. The First Cause of Action, Violation of the Right to Choose the Manner of Execution Provided by Law at the Time of Sentence, alleges that, in enacting SDCL § 23A-27A-32.1, the State of South Dakota created a state statutory right that entitles Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence. The manner of

execution provided by South Dakota law at the time of Rhines's conviction and sentence was, in relevant part, "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch 181, codified at SDCL § 23A-27A-32 (1984.).

The Second Cause of Action, Deprivation of Due Process, alleged that in enacting SDCL § 23A-27A-32.1, the State of South Dakota created life and liberty interests that entitle Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence. (Compl. ¶¶ 51-54.) Rhines's life and liberty interests in being executed in this manner are protected by the Due Process Clause of the Fourteenth Amendment of the United States Constitution and the Due Process Clause of Article Six, Section 2 of the South Dakota Constitution.

The Third Cause of Action, Injunctive Relief, and the Fourth Cause of Action, Declaratory Judgment, sought injunctive and declaratory relief: (1) Staying Rhines's execution pending adjudication of this action; (2) declaring that pentobarbital is neither an ultra-short-acting barbiturate nor a chemical paralytic agent; (3) enjoining the DOC from executing Rhines with pentobarbital; and (4) ordering that the DOC shall execute Rhines only with an ultra-short-acting barbiturate, to wit, sodium methohexital or sodium thiopental, in combination with a chemical paralytic agent.

In light of Mr. Rhines's scheduled execution, he also filed an application for a preliminary injunction, temporary restraining order, or stay of execution to prohibit the DOC from executing him with pentobarbital and to order that the DOC shall execute Rhines only with an ultra-short-acting barbiturate in combination with a chemical paralytic agent.

On October 31, 2019 the Honorable Jon Sogn entered an Order denying the application for preliminary injunction and stay of execution.

5. Appeals of right may be taken only from final, appealable orders. *See* SDCL 15-26A-3 and -4.

   a. Did the trial court enter a final judgment or order that resolves all of each party's individual claims, counterclaims, or cross-claims?

      ___Yes __X__No

      *to the extent this is not a final order, and instead only an order denying preliminary injunction and stay of execution, this Court has jurisdiction under SDCL 15-26A-3(5). *See Hedlund v. River Bluff Estates LLC*, 2018 S.D. 20 (S.D. 2018)

   b. If the trial court did not enter a final judgment or order as to each party's individual claims, counterclaims, or cross-claims, did the trial court make a determination and direct entry of judgment pursuant to SDCL 15-6-54(b)?

      ___Yes __X_No

6. State each issue intended to be presented for review. (Parties will not be bound by these statements)

a. Whether the trial court erred in denying application for preliminary injunction and stay of execution?

b. Whether the trial court erred in concluding the claims are barred by *res judicata*?

c. Whether Mr. Rhines has shown a strong likelihood of success on the merits of his causes of action?

7. Attach a copy of any memorandum opinion and findings of fact or conclusions of law supporting the judgment or order appealed from. *See* SDCL 15-26A-4(2).

a. *See* attached Memorandum Opinion and Order Denying Application for Preliminary Injunction and Stay of Execution

Dated at Sioux Falls, South Dakota, this 31day of October, 2019.

BALLARD SPAHR LLP

FILED
OCT 31 2019
Minnehaha County, S.D.
Clerk Circuit Court

By: _____

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Attorneys for Charles Russell Rhines

...INNEHAHA COUNTY } ss
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on record in my office.
OCT 31 2019
Clerk of Courts, Minnehaha County
_____ Deputy

STATE OF SOUTH DAKOTA	) :SS	IN CIRCUIT COURT
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

CHARLES RUSSELL RHINES, Petitioner vs. SOUTH DAKOTA DEPARTMENT OF CORRECTIONS and MIKE LEIDHOLT, Secretary, South Dakota Department of Corrections, and DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY, Respondent.	49CIV19-002940 **CERTIFICATE OF SERVICE**

The undersigned hereby certifies that on the 31st day of October, 2019, a true and correct copy of *Appellant's Docketing Statement* in the above-entitled matter, was served via U.S. Mail and electronic mail to the following named persons:

Paul S. Swedlund
Assistant Attorney General
1302 East Highway 14 Suite 1
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Email: Paul.swedlund@state.sd.us
Attorneys for Defendant

BALLARD SPAHR LLP

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Attorneys for Plaintiff

FILED
OCT 31 2019
Minnehaha County, S.D.
Clerk Circuit Court

STATE OF SOUTH DAKOTA } ss
COUNTY OF MINNEHAHA }
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on record in my office.
OCT 31 2019
Clerk of Courts, Minnehaha County
By _____ Deputy

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

CHARLES RUSSELL RHINES — Plaintiff and Appellant,

v.

SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, Secretary, South Dakota Department of Corrections, and DARIN YOUNG in his capacity as Warden of the South Dakota State Penitentiary — Defendant and Appellees.

SUPREME COURT
STATE OF SOUTH DAKOTA
FILED
NOV - 1 2019
Clerk

App. No. 29166
49CIV19-002940

Appeal from the Circuit Court, Second Judicial Circuit,
Minnehaha County, South Dakota

The Honorable Jon C. Sogn

MOTION FOR STAY OF EXECUTION

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Attorneys for Appellee and Defendant

INTRODUCTION

This case asks the Court to enforce a set of clear statutory commands from the South Dakota legislature. Pursuant to Section 23A-27A-32.1 South Dakota Codified Laws, no less than seven days before a scheduled execution, a death-sentenced inmate who was convicted or sentenced prior to July 1, 2007 is entitled to elect to be executed in the manner set forth in South Dakota law at the time of his conviction or sentence. In 1993, South Dakota law provided that the punishment of death "shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent…." SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984).

Appellant Charles Russell Rhines was sentenced to death in 1993 and has exercised his right to elect the manner of execution in place at that time, but the State notified him that it would inflict death with pentobarbital, a drug that is neither an "ultra-short-acting barbiturate" nor a chemical paralytic agent. Mr. Rhines therefore brings causes of action that arise out of his statutory rights, his exercise of those rights in accordance with the statutory requirements, and the State's refusal earlier this month to comply with the governing statutes.

The trial court did not reach the merits of this issue, but rather decided that Mr. Rhines's prior habeas litigation that had challenged a prior execution protocol on constitutional grounds likely preclude Mr. Rhines from now enforcing his statutory right. The facts the underlie the basis for the instant claims, however, did not exist at the time of the earlier litigation and only arose after Appellee South Dakota Department of Corrections ("DOC"), in response to Mr. Rhines's timely election and a subsequent letter

from his attorneys, informed Mr. Rhines earlier this month that it would not comply with the statutory mandates.

Unlike any prior litigation, Mr. Rhines today seeks to enforce his state statutory rights. Every issue newly arises out of two statutes and an unforeseen event that occurred earlier this month: the State's refusal to comply with those statutes. This Court should grant Mr. Rhines the relief to which he is entitled to by statute: to be executed with an ultra-short-acting barbiturate and a stay to prevent the State from executing him with a drug that is not an ultra-short-acting barbiturate.

PERTINENT FACTUAL AND PROCEDURAL BACKGROUND

Mr. Rhines is a prisoner sentenced to death by the State of South Dakota, with an execution warrant setting his execution week as between November 3, 2019 and November 9, 2019. Mr. Rhines was sentenced to death on January 29, 1993.

Previously, in 2011, Mr. Rhines litigated whether the legislature's amendments to its execution statute in 2007 and the State's August 2011 protocol complied with the Eighth Amendment standards as set forth by the United States Supreme Court in *Baze v. Rees*, 533 U.S. 35 (2008). *See* Feb. 27, 2013, Op., Trimble, J.at 8. Judge Trimble ultimately determined that the protocol was sufficiently like *Baze* that it was constitutional on its face, *id.* at 10–12, and that South Dakota would implement its protocol in a constitutional manner. *Id.* at 12–18.

In 2018, Mr. Rhines challenged the State's creation of a new execution protocol without complying with the Administrative Procedure Act. *See Rhines v. S. Dakota Dep't of Corr.*, 2019 S.D. 59 (S.D. 2019).

Pursuant to Section 23A-27A-32.1 South Dakota Codified Laws, Mr. Rhines is entitled to elect to be executed in the manner set forth in South Dakota law at the time of his conviction or sentence. In 1993, South Dakota law provided that the punishment of death "shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent…." SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984).

As recently as August 2019, the State provided documents to Mr. Rhines's attorneys regarding sodium thiopental, a drug that is classified as an ultra-short-acting barbiturate with which the State could execute Mr. Rhines in compliance with its law. *See, e.g.*, Exhibit attached to 11/1/2019 Affidavit of Timothy Rahn. For example, in a letter dated April 17, 2012, the State wrote to the Food & Drug Administration and indicated that the State possessed sodium thiopental. *Id.* The State "enclose[ed] the FDA's March 25, 2011, letter authorizing South Dakota's importation of sodium thiopental stock . . . ." *Id.* The State resisted a request from the Food & Drug Administration to "return . . . any foreign-manufactured thiopental . . . ." *Id.*

On October 1, 2019, Mr. Rhines exercised his statutory right to be executed according to the law in effect at the time of his sentence. He sent a Kite-Request Slip to Appellee Darin Young, Warden of the South Dakota State Penitentiary, electing to be executed in the manner that was in effect at the time that he was sentenced to death. In an amended Kite-Request Slip to Warden Young, dated October 4, 2019, Mr. Rhines reiterated his choice to be executed in the manner that was in effect at the time that he was sentenced to death, to wit, "[t]he Two Drug Protocol of a Lethal Dose of An Ultra-Short Acting Barbiturate and a Chemical Paralytic." Warden Young never responded to

these requests and never indicated that the DOC would not comply with Mr. Rhines's election.

On October 15, 2019, attorneys for Mr. Rhines, emailed and mailed a letter to Warden Young, Jason R. Ravnsborg in his capacity as the Attorney General for the State of South Dakota, and Paul Swedlund, Assistant Attorney General. Counsel requested confirmation that Mr. Rhines's request to be executed by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent would be honored. In a letter dated October 17, 2019, Assistant Attorney General Swedlund advised counsel that he had received "Mr. Rhines' request for execution pursuant to the combination of drugs provided by statute at the time of his execution." Mr. Swedlund asserted that "State will follow the law." Mr. Swedlund further informed counsel that "[t]he ultra-short-acting barbiturate the state intends to use is pentobarbital."

On October 22, 2019, Rhines filed an action in the Circuit Court for the Second Judicial Circuit seeking injunctive and declaratory relief to enforce his statutory right under South Dakota law to be executed by the manner he chose.

Rhines's Complaint alleges four causes of action. The First Cause of Action, Violation of the Right to Choose the Manner of Execution Provided by Law at the Time of Sentence, alleges that, in enacting SDCL § 23A-27A-32.1, the State of South Dakota created a state statutory right that entitles Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence. (Compl. ¶¶ 39-44.) The manner of execution provided by South Dakota law at the time of Rhines's conviction and sentence was, in relevant part, "by the intravenous administration of a

lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch 181, codified at SDCL § 23A-27A-32 (1984.) Rhines exercised his right to choose the manner set forth in SL 1984, ch 181. (Compl. ¶ 44.) Rhines did so in accordance with the provisions of SDCL § 23A-27A-32.1. (*Id*.)

The Second Cause of Action, Deprivation of Due Process, alleged that in enacting SDCL § 23A-27A-32.1, the State of South Dakota created life and liberty interests that entitle Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence. (Compl. ¶¶ 51-54.) Rhines's life and liberty interests in being executed in this manner are protected by the Due Process Clause of the Fourteenth Amendment of the United States Constitution and the Due Process Clause of Article Six, Section 2 of the South Dakota Constitution. (*Id.* ¶¶ 55-56.)

The Third Cause of Action, Injunctive Relief, and the Fourth Cause of Action, Declaratory Judgment, sought injunctive and declaratory relief: (1) Staying Rhines's execution pending adjudication of this action; (2) declaring that pentobarbital is neither an ultra-short-acting barbiturate nor a chemical paralytic agent; (3) enjoining the State from executing Rhines with pentobarbital; and (4) ordering that the State shall execute Rhines only with an ultra-short-acting barbiturate, to wit, sodium methohexital or sodium thiopental, in combination with a chemical paralytic agent. (*Id.* ¶¶ 58-71.)

In light of Mr. Rhines's scheduled execution, he also filed an application for a preliminary injunction, temporary restraining order, or stay of execution to prohibit the State from executing him with pentobarbital and to order that the State shall execute

Rhines only with an ultra-short-acting barbiturate in combination with a chemical paralytic agent. Rhines requested an expedited hearing on his application for a preliminary injunction so that the lower court could rule on the application in advance of the execution week beginning November 3, 2019.

The matter was assigned to Judge Jon C. Sogn who scheduled a hearing for October 29, 2019. Late in the evening of October 27, 2019, Assistant Attorney General Swedlund filed a Response to the Motion for Preliminary Injunction, Temporary Restraining Order, and Stay of Execution.

At the October 29, 2019 hearing, Judge Sogn heard argument from counsel and testimony from Dr. Craig Stevens, Ph.D, a professor of Pharmacology at Oklahoma State University. Dr. Stevens explained that barbiturates are classified as ultra-short-acting, short-acting, intermediate-acting, or long-acting. He is not aware of any peer reviewed articles or medical literature that has ever classified pentobarbital as an ultra-short-acting barbiturate. He testified that in his expert opinion, pentobarbital is not an ultra-short-acting barbiturate.

Judge Sogn took the matter under advisement. He invited the parties to submit any additional argument, authority, or affidavits by the following afternoon. On October 30, 2019, Mr. Rhines filed a supplemental memorandum and an affidavit from attorney Fritz offering additional medical and pharmacological authority supporting the fact that pentobarbital is not an ultra-short-acting barbiturate.

Mr. Rhines submitted authoritative medical texts and articles that date back to before 1984, when the legislature wrote the statute at issue, that confirm Dr. Stevens's opinion. Mr. Rhines submitted other authorities specific to the field of anesthesiology

and outside the field of pharmacology that likewise classify pentobarbital as a short-acting barbiturate. Further, Mr. Rhines directed the court's attention to manufacturers of pentobarbital that refer to it as a short-acting barbiturate.

The State made no additional formal filings, although it sent two short e-mails to Judge Sogn to reiterate one argument and to provide a citation for one additional case.

On October 31, 2019, the Second Judicial Circuit Court denied an application for a temporary restraining order and preliminary injunction, and declined to grant a stay of execution. Mr. Rhines filed a notice of appeal that same day.

In addressing whether Mr. Rhines was likely to succeed on the merits of this case, the trial court did not address whether pentobarbital was classified as an ultra-short-acting barbiturate in compliance with the relevant statute. Instead, the trial court held that Mr. Rhines's claims would likely be barred based upon res judicata. To the contrary, Mr Rhines could not have properly litigated this claim in earlier litigation because, as set forth below, Mr. Rhines's prior litigation did not seek enforcement of his statutory rights. The trial court also asserted that Mr. Rhines's request for a stay should be denied because he should have litigated this issue earlier. But the statute at issue did not require Mr. Rhines to elect a method of execution until, at the latest, seven days prior to the execution. And Mr. Rhines did not have reason to believe that Appellees would not honor his request: Appellees had represented to Mr. Rhines's attorneys in August of 2019 that they had an ultra-short-acting barbiturate, sodium thiopental, and; the DOC protocol specifically contemplates executions using sodium thiopental.

Mr. Rhines now seeks a stay of execution pending appeal of that denial and files this emergency appeal to this Court.

STANDARD OF REVIEW

This Court reviews a denial of a temporary restraining order, a preliminary injunction, or a stay of execution for abuse of discretion. *Losee v. Hettich*, 74 S.D. 461, 54 N.W.2d 353 (1952). "An abuse of discretion can simply be an error of law or it might denote a discretion exercised to an unjustified purpose, against reason and evidence." *Hendrickson v. Wagners*, Inc., 1999 SD 74, ¶ 14, 598 N.W.2d 507, 511 (S.D. 1999) (citations omitted) (quoting *Knodel v. Kassel Township*, 1998 SD 73, ¶ 6, 581 N.W.2d 504, 506 (S.D. 1998)).

This Court reviews de novo questions of res judicata. *See Farmer v. S. Dakota Dep't of Revenue & Regulation*, 2010 S.D. 35, 781 N.W.2d 655, 659 (S.D. 2010).

This Court has an inherent power to preserve the status quo pending appeal. *Smith v. Reid*, 60 S.D. 128, 132–33, 244 N.W. 81, 83 (1932); *Gamet v. Allender*, 50 S.D. 150, 208 N.W. 782, 783 (1926). The staying of the execution of a condemned inmate comes within this Court's inherent authority to preserve the status quo. *State v. Robert*, 2012 S.D. 27, ¶ 9, 814 N.W.2d 122, 124-25 (S.D. 2012). This power "'should always be exercised when any irremediable injury may result . . . .'" *Id.* (citing *Merrimack River Sav. Bank v. City of Clay Ctr.*, 219 U.S. 527, 534–35, 31 S. Ct. 295, 296, 55 L. Ed. 320 (1911)). Failing to stay an execution "obviously result[s] in an irremediable injury." *State v. Robert*, 2012 S.D. 27, ¶ 9 (S.D. 2012).

ARGUMENT

I. MR. RHINES HAS DEMONSTRATED THE REQUISITE LIKELIHOOD OF SUCCESS ON THE MERITS TO JUSTIFY A STAY.

This action involves important issues regarding SDCL § 23A-27A-32.1, in which the State of South Dakota codified a statutory right that entitles Mr. Rhines to be executed in the manner provided by South Dakota law at the time of his conviction or sentence. In accordance with that statute, Mr. Rhines exercised his right to choose the manner set forth at the time of his sentence: execution by an ultra-short-acting barbiturate in combination with a chemical paralytic. The State then informed Mr. Rhines that it will use pentobarbital to execute him. Pentobarbital, as discussed *infra* Section I.b., is *not* an ultra-short-acting barbiturate or a chemical paralytic, however. By refusing to follow binding law, the DOC is depriving Rhines of his statutory right.

In deciding a stay motion, courts must decide whether a movant showed a likelihood of success on the merits. *See Strong v. Atlas Hydraulics, Inc.*, 2014 S.D. 69, ¶ 12, 855 N.W.2d 133, 139 (S.D. 2014); *Nelson v. Campbell*, 541 U.S. 637, 649-50 (2004). The likelihood of success does not mean that the inmate will probably win, but rather, that the inmate has shown a "significant possibility" of success. *Nooner v. Norris*, 491 F.3d 804, 808 (8th Cir. 2007) (citing *Hill v. McDonough*, 547 U.S. 573, 584 (2006)). Stays are not granted in instances in which the suit "amounts to little more than an attack on settled precedent" or is based on speculative theories. *See Bucklew v. Precythe*, 139 S. Ct. 1112, 1134 (2019).

a. Mr. Rhines Filed His Action Within Three Business Days of When It Presented a Concrete Case or Controversy With Ripe Issues.

In their response, Appellees raised a defense of res judicata. The trial court decided that Mr. Rhines had not demonstrated the requisite likelihood of success on his causes of action in light of that defense. *See* Order at 22. The heart of the trial court's analysis, however, is an erroneous conclusion it repeats throughout its order: that Mr.

"Rhines challenged the exact protocol in 2011 [that] he is challenging now." Order at 21. That conclusion misconstrues the nature of Mr. Rhines's prior litigation in 2011 and this suit, and it misapplies the law of res judicata.

Unlike any prior litigation, Mr. Rhines today seeks to enforce his state statutory rights. His causes of action are rooted in SDCL § 23A-27A-32.1 and SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984), not the State's protocol. As discussed below, this case could not have presented any court with a justiciable case or controversy or any ripe issue until the DOC notified Mr. Rhines that it refused to comply with Mr. Rhines's statutory rights under SDCL § 23A-27A-32.1 and SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984).

The doctrine of res judicata bars any "attempt to relitigate a cause of action by the parties or one of the parties in privity to a party to an earlier suit." *Dakota Plains AG Ctr., LLC v. Smithey*, 772 N.W.2d 170, 179–80 (S.D. 2009) (quoting *Speck v. Federal Land Bank of Omaha*, 494 N.W.2d 628, 633 (S.D.1993)). "The doctrine 'embodies both merger and bar [.]'" *Id., Black Hills Jewelry Mfg. Co. v. Felco Jewel Indus., Inc.*, 336 N.W.2d 153, 157 (S.D.1983) (citing *Palma v. Powers*, 295 F.Supp. 924 (N.D.Ill.1969)). "'Res judicata serves as claim preclusion to prevent relitigation of an issue actually litigated or which could have been properly raised and determined in a prior action.'" *Id.* (quoting *Black Hills Jewelry Mfg. Co.*, 336 N.W.2d at 157).

Whether an issue could have been properly litigated in an earlier action requires consideration of whether the issue actually had been ripe for determination at the time of that earlier action. *See State v. Hammerquist*, 67 S.D. 417, 293 N.W. 539, 541 (S.D. 1940); *Danforth v. City of Yankton*, 25 N.W.2d 50 (S.D. 1946).

Ripeness involves the timing of judicial review and the principle that the judicial machinery should be conserved for problems that are real and present, not squandered on problems that are abstract, hypothetical, or remote. *Steinmetz v. State, State Star Academy*, 756 N.W.2d 392, 399 (S.D. 2008). For instance, issues that are "dependent upon the future occurrence of conduct and events that were uncertain and unknown" are unripe for judicial determination. *See Boever v. S. Dakota Bd. of Accountancy*, 526 N.W.2d 747, 750 (S.D. 1995). Issues, however, that are "imminent and inevitable" are ripe for review. *Id.* Courts should not render advisory opinions or decide theoretical questions when the future shows no indication of the invasion of a right. *Id.*

Here, as a threshold matter, the trial court misconstrued the nature of Mr. Rhines's causes of action by repeatedly describing them as a "challenge [to] the [execution]s protocol's compliance with the statutes [at issue]," and comparing it to Mr. Rhines's 2011 litigation. *See* Order at 16; *see also id.* at 17 ("Rhines could have and should have brought a specific challenge to the use of pentobarbital as part of his then-pending complaint . . . ."); *id.* at 21 ("Rhines challenged the exact protocol in 2011 as he is challenging it now."). The actual nature of Mr. Rhines's prior litigation and this litigation belie the trial court's analysis.

Earlier, in 2008, Mr. Rhines made constitutional challenges to the State's manner of execution. He sought a ruling that the Eighth Amendment barred "an execution carried out by means of [a] two drug cocktail provided in SDCL 23A-27A-32 in effect at the time of his conviction" and "a declaration that SDCL 23A-27 A-32, as presently codified, and as applied to Rhines, constitute[d] an unconstitutional bill of attainder[,] an unconstitutional ex post facto law[,] and deprive[d] him of his right to due process of the

law." Order at 13. The State adopted a new protocol in 2011, during that litigation, and Judge Trimble later denied relief for all of Mr. Rhines's claims. *See id.* at 13–14. In 2018, Mr. Rhines unsuccessfully challenged the current protocol's promulgation as in violation of the Administrative Procedures Act.

None of those challenges gave Mr. Rhines reason to believe that the State would not use an ultra-short-acting barbiturate if he exercised his statutory right that he seeks to enforce through this litigation. As of October 2019, by statute, Mr. Rhines had the right to elect his method of execution, either by the law currently in place, or by the law in place at the time of his conviction or sentence. The Legislature mandated that he make his election at least seven days prior to his scheduled execution. SDCL § 23A-27A-32.1. There is no dispute that Mr. Rhines complied with the statute governing his election. On October 1, 2019, more than a month before his scheduled execution, Mr. Rhines sent a Kite Request Slip to Darin Young, Warden of the South Dakota State Penitentiary, Mr. Rhines chose to be executed in the manner that was in effect at the time that he was sentenced to death.

Before October 17, 2019, there was no reason to believe that the State would do anything other than abide by the statutory requirement Mr. Rhines had elected, i.e., a lethal dose of an ultra-short acting barbiturate and chemical paralytic agent. The State has possessed an ultra-short-acting barbiturate, sodium thiopental, in the past. Further, the 2011 protocol contemplated the use of sodium thiopental in executions. But the State, on October 17, indicated it would not use sodium thiopental and, instead, advised counsel that "[t]he ultra-short-acting barbiturate the state intends to use is pentobarbital." As discussed *infra* Section I.b., pentobarbital is not an ultra-short-acting barbiturate.

As a result, Mr. Rhines promptly initiated this new action to enforce his statutory rights *after* DOC notified him that it would violate his statutory rights for the very first time. The causes of action in this case therefore arise out of the State's refusal to comply with Mr. Rhines's proper statutory election and events that culminated in the State's mailing of a letter that it would use a short-acting or intermediate-acting barbiturate, but not an ultra-short-acting one. Any litigation therefore was contingent upon the state notifying Mr. Rhines that it was refusing to comply with the statutes at issue. At no earlier point in time did Mr. Rhines "ha[ve] a 'full and fair opportunity to litigate'" these causes of action, let alone "a controversy in which a claim of right is asserted against one who has an interest in contesting it." Order at 19 (quoting *Boever v. South Dakota Bd. Of Accountancy*, 526 N.W.2d 747, 750 (S.D. 1975). Nor were the issues being litigated here previously "ripe for judicial determination." *Id.* (quoting *Boever*, 526 N.W.2d at 750).

For example, the trial court relied on *Lewton v. McCauley*, 460 N.W.2d 728, 730 (S.D. 1990), and *Farmer v. S. Dakota Dep't of Revenue & Regulation*, 2010 S.D. 35, 781 N.W.2d 655 (S.D. 2010), to apply *res judicata* against Mr. Rhines, but these cases support Mr. Rhines's position that *res judicata* is not implicated here. In *Lewton*, this Court found that when facts arise after initial litigation is terminated, and those facts underlie new claims, the doctrine of *res judicata* does not apply. *Letwon*, 460 N.W.2d at 731. If facts "did not exist at the time" of the earlier litigation, *res judicata* cannot be a bar to subsequent litigation. *Id.* By contrast, where a party has "a full and fair opportunity to litigate" its claims in an earlier proceeding, *res judicata* will apply. *Farmer*, 781 N.W. 2d at 661. This Court cautioned that "we should not" "interpret[] the doctrine of res judicata too broadly[.]" *Lewton*, 460 N.W.2d at 730.

If anything, the State's Notice of Adoption of Revised Execution Policy and Protocol dated October 24, 2011, put Mr. Rhines on notice that the DOC ***would*** comply with the law in effect in 1993 if Mr. Rhines so elected, not that it would disregard the statute's plain language. Specifically, the protocol provided that an inmate "shall be executed using the 3- or 1-Drug protocol provided in this document . . . unless the inmate requests in writing . . . that the inmate wishes to be executed by the 2-Drug protocol set forth herein *in accordance with South Dakota law as it existed* prior to July 1, 2007." State's Exhibit 1 at page 3 (emphasis added). This language *imposes a limitation on* the protocol's application to ensure compliance with statutory law as it existed prior to July 2007, i.e., the 1984 statute in this case. Implementation of the 2-drug protocol "in accordance with South Dakota law" requires the DOC to use an ultra-short-acting barbiturate, like thiopental, which, the protocol provides, is indeed an option for use in the execution. Thus, on the face of the Notice, Mr. Rhines had no reason to believe that, if he elected that option, the DOC would fail to comply with the South Dakota law as it existed prior to July 1, 2007 by using an ultra-short-acting barbiturate, because (1) sodium thiopental was an option in the Notice and (2) it stated that Defendants would follow the pre-2007 law.

Although Mr. Rhines's attorneys made this very point in oral argument, the trial court failed to cite this critical portion of the protocol that imposes a *limitation* on the state. Instead, the trial court quoted only a different portion of that paragraph. *See* Order at 13–14. The trial court erroneously gave weight to the fact that the 2011 protocol "listed pentobarbital as one of two drugs that could be administered in the 2-drug protocol." Order at 17. The protocol also listed thiopental, and did not "contain[]

explicit notice of the State's intention to use pentobarbital . . . ." *See* Order at 16. There would have been no foreseeable, let alone ripe, issue regarding the State's use of pentobarbital unless and until the State indicated it would use that drug on an individual sentenced in 1993 who had elected to be executed in the manner required by law in 1993, thus, that the State would not in fact act "in accordance with South Dakota law [in 1993]."

Similarly, this Court should reject the trial court's reasoning that would have required Mr. Rhines to litigate this issue on the *belief* that the State would violate the law by failing to comply with the 1984 statute. The trial court relied on *Boever*, but the *Boever* Court addressed two issues: (1) a challenge involving a quality reviews mandated by statute to occur every three years and (2) a challenge involving a statute that imposes discipline under certain circumstances. *See Boever v. S. Dakota Bd. of Accountancy*, 526 N.W.2d 747, 749–51 (S.D. 1995). The former challenge was ripe, because the issues were "'*imminent and inevitable*.'" Order at 20–21 (quoting *Boever*, 526 N.W.2d at 750) (emphasis added).

Here, however, the State's use of a drug that would violate the 1984 statute was not "bound to happen." In fact, to apply that analysis here, this Court would have to agree that the DOC's refusal to follow the law was "imminent and inevitable." Such a conclusion requires a degree of skepticism about the DOC's responsibilities that this Court should reject. As noted above, the 2011 protocol's own language demonstrates the DOC's recognition of a need to comply with statutory law. Mr. Rhines's action therefore "was dependent upon the future occurrence of conduct and events that were *uncertain*

and unknown," like the "likelihood of future discipline" in *Boever*, and res judicata does not apply. *Id.* at 750.

Moreover, that the DOC included pentobarbital as one of the two possible drugs it would use in its 2011 two-drug protocol is not relevant here. Mr. Rhines is not challenging alternate possibilities presented in that protocol here. His causes of action arise out of two statutes—SDCL § 23A-27A-32.1 and SDCL § 23A-27A-32.1 and SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984)—and the State's refusal to comply with those statutes, not the State's protocol. The trial court also appears to treat *notice* of *possible* State action as sufficient to confer standing and make the issues in this case ripe, going so far as to conclude that, "[b]ecause the . . . prior litigation specifically talked about both drugs [(pentobarbital and thiopental)], the protocol, and the statute, Rhines was bound to bring the claims at that time." *See* Order at 16 (reasoning that "Rhines was put on notice of the adoption and revision of the protocol."). Yet a State's "talk[ing] about" multiple options does not create a justiciable case or controversy or a make a possible issue ripe for judicial determination.

In fact, as recently as August 2019, the State provided documents to Mr. Rhines's attorneys regarding thiopental, a drug that actually is an ultra-short-acting barbiturate with which the State could execute Mr. Rhines in compliance with state law. *See, e.g.*, Exhibit attached to 11/1/2019 Affidavit of Timothy Rahn. One of those documents is a letter dated April 17, 2012, in which the Office of the Attorney General of South Dakota wrote to the Food & Drug Administration. *See id.* The Attorney General indicated that the State possessed thiopental and "enclose[ed] the FDA's March 25, 2011, letter authorizing South Dakota's importation of sodium thiopental stock . . . ." *Id.* The State

resisted a request from the Food & Drug Administration to "return . . . any foreign-manufactured thiopental . . . ." *Id.*

If Appellees were not prepared to comply with statute they could have, at any time, either sought an amendment to SDCL § 23A-27A-32.1 or could have sought relief from the court from compliance with the statute. They did not.

In sum, before October 2019, any issues concerning the State's willingness to follow the law in effect at the time of Mr. Rhines's sentence would have been based on speculation about future actions that may or may not occur. Those issues were not ripe at that time and, thus, res judicata does not bar this action. Accordingly, this Court should reverse the trial court's order and grant Mr. Rhines the relief he seeks: to be executed with an ultra-short-acting barbiturate and a stay to prevent the State from executing him with a drug that is not an ultra-short-acting barbiturate.

b. The Trial Court Fails to Address Mr. Rhines's First Cause of Action, that Appellees Violated His Statutory Rights, A Cause of Action Upon Which Mr. Rhines is Likely to Succeed.

Affirming the trial court's ruling would permit the DOC to violate the plain language of binding statutory law. The trial court did not address this issue, but Mr. Rhines clearly met his burden to justify temporary relief or, in the alternative, final judgment requiring the DOC to comply with the law.

Mr. Rhines is likely to succeed on the merits of his cause of action alleging a violation of state statutory law. The plain language of the statutes at issue is clear. In enacting SDCL § 23A-27A-32.1, the State of South Dakota entitled Rhines to be executed in the manner provided by South Dakota law at the time of his conviction or sentence. *See* SDCL § 23A-27A-32.1.

In the trial court, Rhines relied on the unambiguous language of the execution statute at the time of his conviction and sentence. At the time of his conviction and sentence, the execution statute used the precise term "ultra-short-acting barbiturate" as the necessary first drug in an execution. SL 1984, ch 181, codified at SDCL § 23A-27A-32 (1984). "The intent of a statute is determined from what the legislature *said, rather than what the courts think it should have said,* and the court must confine itself to the language used. Words and phrases in a statute must be given their plain meaning and effect." *Rhines v. S. Dakota Dep't of Corrs.*, 2019 S.D. 59, ¶ 13 (2019) (emphasis added).

That term "ultra-short-acting barbiturate" had, and continues to have, a clear meaning, as demonstrated by substantial evidence in the record before this Court. Pentobarbital, which the state has indicated it plans to use as an "ultra-short-acting barbiturate," is not classified as an ultra-short-acting barbiturate.

i. The State Is Violating Its Statutory Obligation to Execute Rhines with an Ultra-Short-Acting Barbiturate in Combination with a Chemical Paralytic Agent.

The plain language of the statutes at issue is clear. SDCL § 23A-27A-32.1 entitles Mr. Rhines to be executed in the manner provided by South Dakota law at the time of his sentence. *See* SDCL § 23A-27A-32.1. The South Dakota Legislature enacted this provision in February of 2007 and made no changes to it when the Legislature amended portions of § 23A-27A-32 in 2008.

When Mr. Rhines was convicted and sentenced, in 1993, South Dakota law provided, in pertinent part, and unequivocally, that "[t]he punishment of death *shall* be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting

barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch. 181 (emphasis added). The statute allows no discretion in the manner of execution, but rather gives specific directives as to the manner of execution. Accordingly, SDCL § 23A-27A-32.1 and SL 1984, ch. 181, codify a right to an execution "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent." SL 1984, ch. 181.

Pursuant to the SDCL § 23A-27A-32.1, Mr. Rhines shall be executed in this manner if he "choose[s] by indicating in writing to the warden not less than seven days prior to the scheduled week of execution the manner of execution chosen." SDCL § 23A-27A-32.1. Mr. Rhines chose to be executed in this manner—more than 4 weeks prior to the week of his execution—in a written Kite-Request Slip dated October 1, 2019, addressed to Defendant Young, and in an amended written Kite-Request Slip dated October 4, 2019, addressed to Defendant Young. (Compl. ¶¶ 30, 31, Exhibits B, C to the Compl.) Based upon the foregoing, Mr. Rhines has demonstrated that he has a right to be executed in the manner he has chosen arising from South Dakota Codified Law.

The DOC cannot deprive Rhines of his right to be executed in the manner of his choice. The DOC, however, has taken the position that pentobarbital is an ultra-short-acting barbiturate. (Compl. ¶ 34, Exh. E to the Compl.) The DOC's assertion is erroneous and contradicted by substantial record evidence, as discussed in more detail below. Pentobarbital is not an ultra-short-acting barbiturate. (Compl. ¶ 36; Stevens Aff. ¶¶ 7, 8.) Ultra-short-acting barbiturates include sodium methohexital and sodium

thiopental. (Compl. ¶ 35; Stevens Aff. ¶ 7.) The statute's plain language requires that the State use an ultra-short-acting barbiturate. By refusing to guarantee that Rhines will be executed in the manner set forth in SL 1984, ch. 181, the State is depriving Rhines of his state statutory right codified and protected by SDCL § 23A-27A-32.1, and SL 1984, ch. 181.

This case is analogous to *Smith v. State*, No. BDV-2008-303, 2015 WL 5827252 (Mont. Dist. Oct. 6, 2015) (Exh. A to the Compl.). In *Smith*, the Court addressed a similar Montana law that provided "[t]he punishment of death must be inflicted by administration of a continuous, intravenous injection of a lethal quantity of an ultra-fast-acting barbiturate in combination with a chemical paralytic agent until a coroner or deputy coroner pronounces that the defendant is dead." *Id.* at *1. However, the State of Montana intended to execute Smith using pentobarbital, which, Smith argued, is not an ultra-fast-acting barbiturate. *Id.* After a trial, the court concluded, among other things, that pentobarbital is not an ultra-fast-acting barbiturate and enjoined the State of Montana from executing Smith using pentobarbital. *Id.* at *6. The court credited the fact that "the terms ultra-fast and ultra-short refer to the same type of barbiturates, as do the terms fast and short, and as do the terms slow and long." *Id.* at *3.

The Montana statute at issue in *Smith* and SL 1984, ch. 181, are nearly verbatim. The evidence presented by Mr. Rhines demonstrates, as was demonstrated in *Smith*, that pentobarbital is not an ultra-short-acting barbiturate. Thus, just as Smith succeeded on the merits of his claims, Mr. Rhines is likely to succeed on the merits of his.

ii. Overwhelming Evidence Confirms that Pentobarbital Is Not an Ultra-Short-Acting Barbiturate.

The evidence presented at the hearing overwhelmingly shows that pentobarbital is not an ultra-short-acting barbiturate. Dr. Craig Stevens, a professor of pharmacology at Oklahoma State University, testified and explained that barbiturates are classified as either ultra-short-acting, short-acting, intermediate-acting, or long-acting, depending upon their chemical properties. The relevant property is lipid solubility. The most lipid-soluble barbiturates are sodium thiopental and methohexital, which are thus classified in the literature as ultra-short-acting. Pentobarbital is less lipid-soluble than sodium thiopental and methohexital to a significant degree and is classified as a short-acting barbiturate.

Barbiturates' lipid solubility does not change depending upon the dose or setting. Dr. Stevens is not aware of any peer-reviewed articles or medical literature that has ever classified pentobarbital as an ultra-short-acting barbiturate. He testified unequivocally that pentobarbital is not classified as an ultra-short-acting barbiturate.

Dr. Stevens's opinion is consistent with authoritative medical texts and articles that date back to before 1984, when the legislature wrote the statute at issue. *See, e.g.*, Linda Lilley, et al., Pharmacology and the Nursing Process 189 (9th ed. 2020) (including classification chart listing thiopental as ultrashort-acting barbiturate and pentobarbital as short-acting barbiturate); PHARMACOLOGY 111 fig. 9.7 (Richard A. Harvey & Pamela C. Champe eds.) (4th ed. 2009) (classifying pentobarbital as short-acting and thiopental as ultra-short-acting); Carl Burtis, et al., Tietz Textbook of Clinical Chemistry and Molecular Diagnostics 1325-26 & Table 34.10 (4th ed. 2006) (identifying thiopental as ultrashort-acting barbiturate and pentobarbital as short-acting barbiturate); Francisco López-Muñoz, et al., The History of Barbiturates a Century After Their Clinical

Introduction, NEUROPSYCHIATRIC DISEASE AND TREATMENT, Vol. 1(4), 329-43, Table 3 (Dec. 2005) (reproducing table from 1983 classifying pentobarbital as short-acting and thiopental as ultrashort-acting); *see also* 1 Lawyers' Guide to Medical Proof § 106.02 (2019) (listing ultrashort-acting barbiturates "in current medical use" as methohexital, thiamylal, and thiopental, and listing pentobarbital among the short-acting and intermediate-acting barbiturates); 9 Attorneys Textbook of Medicine (Third Edition) P. 51.10 (2019) (listing ultrashort-acting barbiturates as thiopental, thiamylal and methohexital); 12-256-9A Courtroom Medicine Series: Psychic Injuries § 9A.50 ("Ultra-short-acting barbiturates include thiopental (half-life of 6 to 46 hours; Schedule III) and methohexital (1 to 2 hours; Schedule IV); the short-acting group includes pentobarbital (Nembutol; 15 to 48 hours; Schedule II; III) . . . .").

The affidavit of Dr. Antognini, submitted by the State, does not contradict this. While it suggests that the duration of pentobarbital's effects changes with a larger dose, he significantly omits any conclusion that pentobarbital is or has ever been classified as an ultra-short-acting barbiturate. Moreover, courts have found that Dr. Antognini's opinions in the death penalty context are "shown to be an outlier in the field of anesthesiology." *In re Ohio Execution Protocol Litigation*, 2019 WL 244488 at * 62 (S.D. Oh. January 14, 2019) (slip opinion). Appellees were provided with an opportunity to provide a supplemental affidavit to contradict Dr. Stevens testimony, and Appellees failed to do so.

At the hearing, the State asserted that the fact that pentobarbital is sometimes classified as short-acting or intermediate-acting is proof that classifications can change. This assertion only stands for the idea that pentobarbital falls in the middle range. It does

not mean, and the State failed to submit any evidence to support a conclusion, that the classification of pentobarbital has ever been ultra-short-acting. The classification of barbiturates as "ultra-short-acting" is the only issue to which the legislature has directed the State and this Court.

The State also suggested—without any evidence—that anesthesiologists do not categorize barbiturates in the same manner as pharmacologists do. To the contrary, the court in *Smith*, cites Margaret Wood and Alistair J.J. Wood's text, I (2d. ed.,Williams & Wilkins 1989), in support of the statement that "[b]arbiturates are traditionally classified as long-acting (phenobarbital), medium-acting (such as pentobarbital), short-acting (secobarbital), and ultra-short-acting (thiopental)." *Smith*, 2015 WL 5827252, at *2. The State has cited an article on neurosurgical anesthesia to support its argument, *see* Response Mot. Prelim. Inj. 14, but that article itself recognizes that pentobarbital is not an ultra-short-acting barbiturate: "[L]ittle is known about the hemodynamic effects of pentobarbital in humans, at least when given in the doses needed for neurosurgical purposes. *This contrasts with the large body of data concerning the effects of the ultrashort-acting anesthetic barbiturates such as thiopental*."). Todd, Drummond and Sang, Hemodynamic Effects of High Dose Pentobarbital: Studies in Elective Neurosurgical Patients, 20 NEUROSURGERY 559 (1987) (emphasis added).

Other authorities specific to the field of anesthesiology and outside the field of pharmacology likewise classify pentobarbital as a short-acting barbiturate. *See*, *e.g.*, Helen Lamb, The barbiturates: with particular reference to their use in anesthesia. Bulletin of the American Association of Nurse Anesthetists. 1943;12(4): 228-29 (identifying pentobarbital as a barbiturate "of moderate duration" while identifying

evipal, pentothal, and thio-ethymal as "ultra-short-acting barbiturates"); Torben Seear, Pentobarbital Anesthesia in Labor, M.D. American Journal Of Obstetrics And Gynecology, Vol. 99, Issue 7, p. 955 (Dec. 1967) ("Pentobarbital is a short-acting, but not ultrashort-acting barbiturate."); Bryson, Peter D. *Comprehensive Review in Toxicology for Emergency Clinicians* 464 (3d. ed. 1996) (classifying Pentobarbital in the "Short – and Intermediate-acting" Barbiturate classification as opposed to the "Ultrashort-acting" classification); Sandra J. Cunningham & Waseem Hafeez, "Procedural Sedation and Pain Management Techniques," Textbook of Pediatric Emergency Procedures 423 (Christopher King & Fred M. Henretig eds., 2d ed. 2008) (identifying pentobarbital as "a short-acting barbiturate," as opposed to methohexital which is an "ultrashort-acting barbiturate").

Further, manufacturers of pentobarbital refer to it as a short-acting barbiturate. Not only does the FDA-approved branded manufacturer's insert for Nembutal Sodium Solution, which is the manufacturer's name for pentobarbital, state: "NEMBUTAL Sodium is a short-acting barbiturate," (Fritz Exh. 4), but the manufacturers for generic pentobarbital, Sagent and Leucadia, similarly state that pentobarbital is a short-acting barbiturate. *See* https://www.sagentpharma.com/wp-content/uploads/2017/11/Pentobarbital_PI-Revised.pdf; http://leucadiapharma.com/wp-content/uploads/2018/02/Pentobarbital_PI_Art_Clean.pdf.

The State repeatedly mischaracterized testimony on the classification of barbiturates from a different expert, Dr. Mark Heath, in different litigation. Dr. Heath's testimony supports Rhines's position. Dr. Heath used the terms "ultra-short" and "ultra-fast" interchangeably, and he consistently referred to that category of barbiturates in

"*contrast*" with pentobarbital. *Compare* State's Exhibit 8 at transcript page 21–22 ("I'll just start by comparing ultra-short and ultra-fast-acting barbiturates which will enter the brain very quickly in a matter of tenths of seconds, and will also leave the brain very quickly . . . . and those drugs would be the class of drug would be thiopental, for example, and another would be a drug called methohexital.") *with id.* at transcript page 22 ("*By contrast*, pentobarbital is slower to take effect and lasts for longer." (emphasis added)).

The State pulled quotations out of context, but even these quotations never established that this different expert classified pentobarbital as "ultra-short-acting." *See, e.g.*, State's Exhibit 11 at transcript page 90 (explaining that the line dividing ultrafast from fast-acting barbiturates "is really a molecular line. . . . . [Molecular] modifications have created a class unto itself."). The State goes so far as to repeatedly cite the expert's testimony in *Smith*, the very premise of which was that pentobarbital is not an ultra-short-acting barbiturate. Thus, that there are "different ways" to classify barbiturates does not change that Dr. Heath never placed pentobarbital in any sort of "ultra-short" or "ultra-fast" category. *See* State's Exhibit 8 at transcript page 21.

Consistent with this evidence, numerous cases have recognized that pentobarbital is not classified as an ultra-short-acting barbiturate. *See McGehee v. Texas Dep't of Criminal Justice*, No. MC H-18-1546, 2018 WL 3996956, at *2 (S.D. Tex. Aug. 21, 2018) ("Testimony in other cases has established that pentobarbital is 'not classified as an ultra-short-acting barbiturate.' *Mann v. Palmer*, 713 F.3d 1306, 1313 (11th Cir. 2013)."); *Bible v. Davis*, No. 4:18-CV-1893, 2018 WL 3068804, at *1 (S.D. Tex. June 21, 2018) ("Pentobarbital is an intermediate-acting barbiturate") (internal quotation omitted), aff'd,

739 F. App'x 766 (5th Cir. 2018); *West v. Schofield*, 519 S.W.3d 550, 553 (Tenn. 2017) (stating that pentobarbital is "described in [Tennessee's execution] Protocol as 'an intermediate-acting barbiturate'") (internal brackets omitted); *Grayson v. Warden, Comm'r, Alabama State*, 869 F.3d 1204, 1210 (11th Cir. 2017) (describing "pentobarbital, [as] a short-acting barbiturate sedative") (internal quotation marks omitted); *West v. Warden, Comm'r, Alabama State*, 869 F.3d 1289, 1292 (11th Cir. 2017) (describing "pentobarbital, [as] a short-acting barbiturate sedative") (internal quotation marks omitted); *Whitaker v. Livingston*, No. CV H-13-2901, 2016 WL 3199532, at *1 (S.D. Tex. June 6, 2016) ("Pentobarbital is an intermediate-acting barbiturate."), *aff'd sub nom. Whitaker v. Collier*, 862 F.3d 490 (5th Cir. 2017); *Smith v. Montana*, No. BDV-2008-303, 2015 WL 5827252, *2 (Oct. 6, 2015) ("Barbiturates are traditionally classified as long-acting (phenobarbital), medium-acting (such as pentobarbital), short-acting (secobarbital), and ultra-short-acting (thiopental)."") (Exh. A to the Compl.); *Trottie v. Livingston*, No. CV 4:14-2550, 2014 WL 12527181, at *2 (S.D. Tex. Sept. 5, 2014) ("pentobarbital . . . is an intermediate-acting barbiturate.") (internal quotation omitted); *Arthur v. Thomas*, 974 F. Supp. 2d 1340, 1345 (M.D. Ala. 2013) ("Sodium thiopental is classified as an 'ultra-short acting barbiturate,' while pentobarbital is an 'intermediate-acting barbiturate.' As these classifications indicate, sodium thiopental has an extremely rapid onset of effect and subsequent recovery, while pentobarbital is slower and longer-acting."); *Arthur v. Thomas*, 674 F.3d 1257, 1274 (11th Cir. 2012) ("sodium thiopental is 'ultrashort-acting,' while pentobarbital is 'intermediate-acting'") (internal quotation and citation omitted); *Powell v. Thomas*, 643 F.3d 1300, 1304 (11th Cir. 2011) ("sodium thiopental is 'ultrashort-acting,' while pentobarbital is 'intermediate-acting'") (internal

quotation and citation omitted); *In re Jacoby Airplane Crash Litig*., No. CIV.99-6073 (HAA), 2007 WL 5037683, at *22 (D.N.J. Aug. 27, 2007) ("The ultrashort-acting barbiturates produce anesthesia within about one minute after intravenous administration.... Barbiturate abusers prefer the Schedule II short-acting and intermediate-acting barbiturates that include amobarbital (Amyta®), pentobarbital (Nembutal®), secobarbital (Seconal®), and Tuinal (an amobarbital/secobarbital combination product).") (internal quotation and citation omitted). Nearly all of these cases arose in the lethal injection context thus belying the State's suggestion that pentobarbital's classification changes to ultra-short-acting when it is used in lethal doses for execution.

The State cited cases that, it claimed, indicate the absence of a difference between sodium thiopental and pentobarbital. As described during the hearing, those cases arose in the context of Eighth-Amendment or constitutional challenges focused on various execution protocols' likelihood to produce unnecessary suffering. Not one of these cases states that pentobarbital ever has been classified as an ultra-short-acting barbiturate, the only issue before this Court. In fact, undersigned counsel is aware of no case that identifies pentobarbital as an ultra-short-acting barbiturate.

The legislature used plain language in the statutes at issue. The DOC must follow that language. Just as the *Smith* court held, had the legislature intended to give the State of South Dakota latitude in what drugs to use, it could have used much more general language in the statute authorizing execution. Instead of "ultra-short-acting barbiturate," the legislature could have said "intermediate- or short-acting barbiturates in doses that

have the effect of ultra-short-acting barbiturates." Indeed, it later amended the statute to read "a substance or substances in a lethal quantity." SDCL 23A-27A-32.

Courts may not legislate through judicial interpretation of statutes, and this Court should grant a stay of execution to correct the trial court's error and ensure that the DOC follows the clear mandate of the legislature.

The State's assertion that the legislature intended to use the term "ultra-short-acting barbiturate" as "limited to its properties as a lethal agent" has no basis in the text of the statute. It amounts to post hoc speculation by the State to justify its choice of pentobarbital.

Three additional reasons undermine the State's attempt to legislate through this Court. First, if the State's interpretation were correct, it would render meaningless the legislature's subsequent decision to remove the phrase "ultra-short-acting barbiturate" and replace it with "substance or substances in a lethal quantity." *See* SDCL 23A-27A-32. Second, even before 1984, the term ultra-short-acting barbiturate had a well-known and well-defined meaning that did not include pentobarbital. Francisco López-Muñoz, et al., The History of Barbiturates a Century After Their Clinical Introduction, NEUROPSYCHIATRIC DISEASE AND TREATMENT, Vol. 1(4), 329-43, Table 3 (Dec. 2005) (reproducing table from 1983 classifying pentobarbital as short-acting and thiopental as ultrashort-acting). Third, the statute expressly references "standards of medical practice," indicating that it did not legislature in a vacuum, let alone the State's speculative "lethal agent" vaccum. *See* SL 1984, ch. 181, codified at SDCL § 23A-27A-32 (1984). ("The punishment of death shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical

paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice.").

c. The Trial Court's Failure to Adjudicate the Merits of Mr. Rhines's Due Process Claim and its Improper Application of Res Judicata to Deny an Injunction or a Stay Denied Mr. Rhines Due Process Under the US Constitution.

The lower court's failure to adjudicate the merits of his due process claim and its improper application of res judicata to deny an injunction or a stay likewise denied due process guaranteed by the Fourteenth Amendment of the U.S. Constitution. At its core, the Due Process Clause guarantees a party not only "the opportunity to present his case," but also the right "to have its merits fairly judged." *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 433 (1982). Thus, to satisfy due process, a hearing must fairly and reliably establish all the facts that the relevant law requires before a person may be deprived of his life and liberty. *See Bell v. Burson*, 402 U.S. 535, 542 (1971).

In *Fayerweather v. Ritch*, 195 U.S. 276, 307 (1904), the Court held that, as a matter of due process, no court may preclude a party from litigating an issue that had not been actually decided in a prior adjudication. The Court also confirmed that when evidence has been "offered at [a] prior trial upon several distinct issues, the decision of any one of which would justify the verdict or judgment, then the conclusion must be that the prior decision is not an adjudication upon any particular issue or issues, and the plea of res judicata must fail." *Id*. at 307.

Here, the lower court's ruling had the same effect. Its improper denial of a temporary injunction or stay without addressing the merits denied due process.

d. The Trial Court Failed to Address Mr. Rhine's Second Cause of Action, that Appellees Deprived Mr. Rhines of His Life and Liberty Interests Protected by the Due Process Clause of the U.S. Constitution and the South Dakota Constitution, A Cause of Action Upon Which Mr. Rhines is Likely to Succeed.

Mr. Rhines is likely to succeed on the merits of his cause of action alleging deprivation of due process. "Procedural due process constrains government decisions 'which deprive individuals of 'liberty' or 'property' interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment.'" *Kroupa v. Nielsen*, 731 F.3d 813, 818 (8th Cir. 2013) (quoting *Mathews v. Eldridge*, 424 U.S. 319, 332 (1976)). "'To establish a procedural due process violation, a plaintiff must demonstrate that he has a protected property or liberty interest at stake and that he was deprived of that interest without due process of law.'" *Osloond v. Farrier*, 659 N.W.2d 20, 24 (S.D. 2003) (quoting *Hopkins v. Saunders*, 199 F.3d 968, 975 (8th Cir. 1999) (citation omitted)). "[S]tate law may create a 'liberty interest' protected by the Fourteenth Amendment… [i]f, for example, a state statute gives 'specific directives to the decision maker that if the [statute's] substantive predicates are present, a particular outcome must follow,' a 'liberty interest' protected by the Fourteenth Amendment is created." *Bagley v. Rogerson*, 5 F.3d 325, 328 (8th Cir. 1993) (quoting *Kentucky Department of Corrections v. Thompson*, 490 U.S. 454, 463 (1989)); *see Hicks v. Oklahoma*, 447 U.S. 343, 346 (1980) (Oklahoma statute providing jury could impose a sentence of no fewer than 10 years in prison created a liberty interest protected by the 14th Amendment in defendant having the jury apply that sentence). To constitute a due process violation, the individual must have been deprived

of this right by a state actor. *See Osloond v. Farrier*, 659 N.W.2d 20, 24 (S.D. 2003)*; DeShaney v. Winnebago County Dep't of Soc. Servs*., 489 U.S. 189, 195, (1989).

After the State enacted SDCL § 23A-27A-32.1, Mr. Rhines had life and liberty interests that entitle him to be executed in the manner provided by South Dakota law at the time of his conviction or sentence. *See* SDCL § 23A-27A-32.1; *Ohio Adult Parole Auth. v. Woodard*, 523 U.S. 272, 289 (1998) (O'Connor, J.) ("A prisoner under a death sentence remains a living person and consequently has an interest in his life."). Here, in enacting SDCL § 23A-27A-32.1, the State of South Dakota created life and liberty interests that entitle Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence. *See* SDCL § 23A-27A-32.1. The South Dakota Legislature enacted this provision in February of 2007 and made no changes to it when the Legislature amended portions of § 23A-27A-32 in 2008.

At the time that Rhines was convicted and sentenced, in 1993, South Dakota law provided, in pertinent part, and unequivocally, that "[t]he punishment of death ***shall*** be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch.181 (emphasis added). The statute allows no discretion in the manner of execution, but rather gives specific directives as to the manner of execution. *See Bagley*, 5 F.3d at 328. Accordingly, SDCL § 23A-27A-32.1 and SL 1984, ch.181 create protected life and liberty interests in execution "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until

the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch.181.

As set forth in Secion I, *supra*, South Dakota Codified Law mandates that Rhines shall be executed in this manner if he chooses it more than seven days before his execution week, which he did. (Compl. ¶¶ 30, 31, Exhibits B, C to the Compl.) Based upon the foregoing, Rhines has demonstrated that he has protected life and liberty interests in being executed in the manner he has chosen arising from South Dakota Codified Law. *See Osloond*, 659 N.W.2d at 24.

The State cannot deprive Rhines of his life and liberty interests without due process of law to which he is entitled under the due process clauses of the Fourteenth Amendment of the United States Constitution and Article Six, Section 2 of the South Dakota Constitution. *See* U.S. Const. amend. XIV, § 1; S.D. Const. art. XI, § 2. Pentobarbital is neither an ultra-short-acting barbiturate nor a chemical paralytic. (Compl ¶ 36; Stevens Aff. ¶¶ 7, 8, 11.) Ultra-short-acting barbiturates include sodium methohexital and sodium thiopental. (Compl ¶ 35; Stevens Aff. ¶ 7.) By stating that Rhines will be executed using pentobarbital, which is not an ultra-short-acting barbiturate, the State is deliberately and intentionally depriving Rhines of his constitutionally protected life and liberty interests without due process of law. Based upon the foregoing, Rhines is likely to succeed on the merits of his Second Cause of Action.

The lower court's failure to adjudicate the merits of his due process claim and its improper application of res judicata to deny an injunction or a stay likewise denied due process. At its core, the Due Process Clause guarantees a party not only "the opportunity

to present his case," but also the right "to have its merits fairly judged." *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 433 (1982). Thus, to satisfy due process, a hearing must fairly and reliably establish all the facts that the relevant law requires before a person may be deprived of his life and liberty. *See Bell v. Burson*, 402 U.S. 535, 542 (1971). The lower court's improper denial of a temporary injunction or stay without addressing the merits did not comport with these principles.

II. THIS COURT HAS THE AUTHORITY TO STAY RHINES'S EXECUTION AND SHOULD EXERCISE IT HERE TO AVOID IRREMEDIABLE INJURY TO RHINES.

The Court should exercise its authority to stay Rhines's execution. If Mr. Rhines is executed pursuant to a procedure that does not accord with the law, it is axiomatic that the harm he will suffer is irreparable, because he will be dead. As the U.S. Supreme Court has recognized, "'[d]eath is a punishment different from all other sanctions in kind rather than degree." *Woodson v. North Carolina*, 428 U.S. 280, 303–04 (1976).

The trial court erred when it concluded that the irreparable harm prong neither favored Mr. Rhines nor the State. The harm Mr. Rhines seeks to avoid is an execution that violates the law that applies to his sentence. Rather than assessing the irreparability of the harm, the court simply summarized the State's arguments on the merits, which are irrelevant to this prong. *See supra* Section I.

Rhines's death by execution is an irremediable injury that should be avoided until this Court rules on whether the State's use of pentobarbital complies with Rhines's statutory rights under South Dakota law. If the State is permitted to execute Rhines using pentobarbital before this issue is decided, Mr. Rhines will be deprived of his statutory

right without any possible remedy. Therefore, this Motion for Stay of Execution should be granted.

III. THE BALANCE OF THE EQUITIES FAVORS A STAY.

In balancing the equities, the court reasoned that the DOC has "a strong interest in enforcing its criminal judgments," *see* Order at 10 (citing *Hill v. McDonough*, 547 U.S. 573, 584 (2006), and that there is a "strong equitable presumption" against stays where claims could have been brought earlier," *see* Order at 10–11 (quoting *Nelson v. Campbell*, 541 U.S. 637, 650 (2004)). *See also* Order at 11 (citing *Ledford v. Comm'r, Georgia Dep't of Corr.*, 856 F.3d 1312, 1319–20 (11th Cir. 2017); *Jones v. Allen*, 485 F.3d 635, 640 (11th Cir. 2007)).

As discussed *supra* Section I.a., Mr. Rhines could not have raised his issues earlier, has not delayed, and had no reason to think he needed to raise these issues earlier. Further, he had no reason to believe that he had a need to raise it. Appellees indicated in the 2011 protocol that they could use sodium thiopental if he elected the 2-drug protocol in effect at the that he was sentenced. Even as late as August of 2019 Appellees provided his counsel with information that suggested they possessed sodium thiopental. Mr. Rhines made his election in a timely manner and filed this suit promptly after the State, for the first time, notified him that it would violate the law.

Each of the federal cases cited by the trial court are inapposite. The petitioners in each case waited years after their claims were ripe before they filed suit. *See Hill*, 547 U.S. at 576–77; *Nelson*, 541 U.S. at 649; *Ledford*, 856 F.3d at 1315–16; *Jones*, 485 F.3d at 638–39. By contrast, Mr. Rhines filed a timely suit, shortly after his cause of action became ripe, and only after the state put him on notice, for the very first time, that it

would violate the law. Neither the delay nor the piecemeal litigation at issue in *McGehee v. Hutchinson*, 854 F.3d 488, 492 (8th Cir. 2017), is applicable to this current litigation. In *McGehee*, the petitioners filed suit in state court challenging the 2015 adoption of a method of execution under both the state and federal constitutions. *Id.* at 491. When the state removed to federal court, the petitioners voluntarily dismissed the case and filed a new action in state court, omitting the federal constitutional claim. *Id.* Only after losing the state constitutional challenge, and just three weeks before the first of eight executions scheduled in March 2017, the petitioners again brought a federal constitutional challenge to the 2015. *Id.*

Moreover, the Eighth Amendment challenges raised in each of these cases related to the amount of suffering the petitioners would experience when executed, not whether the execution was, itself, in violation of state law. Mr. Rhines's challenge, by contrast, seeks only to secure his right to be executed in accordance with the very statute that empowers the State to take his life. *Cf. Ericksen v. City of Sioux Falls*, 14 N.W.2d 89, 95 (S.D. 1944) (reasoning that a city "has no inherent powers and none of the attributes of sovereignty" and "possesses only such powers, great or small, as [the Constitution and statutes of the state] give it").

The State seeks to carry out the most solemn and irrevocable act of government without compliance with the statute that alone authorizes the DOC to take such an act. Any potential inconvenience of using the mandated drug does not counterbalance the harm that Mr. Rhines will suffer when he is executed in violation of the law, or the public interest in knowing that the DOC is conducting executions that are contrary to the authority granted to them by state statutes carefully outlined by its legislators.

IV. THE PUBLIC INTEREST FAVORS A STAY AND COMPLIANCE WITH THE STATUTES AT ISSUE.

As the trial court itself recognized, "[t]he public has a strong interest in making sure the State complies with laws passed by our legislature." Order at 11. "This interest is magnified when the State is carrying out the ultimate criminal penalty—death." Order at 11–12.

CONCLUSION

Mr. Rhines has met the requirements of a stay of execution and for this Court to reverse the trial court's order. For all the reasons set forth above, Mr. Rhines respectfully requests that the Court grant a stay of execution and issue a temporary restraining order, ordering that: (1) pentobarbital is neither an ultra-short-acting barbiturate nor a chemical paralytic agent; (2) the DOC is enjoined from executing Mr. Rhines with pentobarbital, and (3) the DOC shall execute Mr. Rhines only with an ultra-short-acting barbiturate (such as sodium methohexital or sodium thiopental) in combination with a chemical paralytic agent. In the alternative, Rhines requests an expedited hearing and a determination of the merits of his causes of action.

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on November 1, 2019, two (2) true and correct copies of the foregoing *Motion for Stay of Execution* were served by prepaid U.S. Mail and electronic mail upon the following:

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SUPREME COURT
STATE OF SOUTH DAKOTA
FILED

NOV - 1 2019

Clerk

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

CHARLES RUSSELL RHINES — Plaintiff and Appellant,

v.

SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, Secretary, South Dakota Department of Corrections, and DARIN YOUNG in his capacity as Warden of the South Dakota State Penitentiary — Defendant and Appellees.

App. No. _____
49CIV19-002940

Appeal from the Circuit Court, Second Judicial Circuit,
Minnehaha County, South Dakota

The Honorable Jon C. Sogn

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JURISDICTIONAL STATEMENT

The Plaintiff/Appellant Charles Russell Rhines (Rhines) appeals the Second Judicial Circuit's Memorandum Opinion and Order Denying an Application for a Temporary Restraining Order, Preliminary Injunction, and Stay of Execution, which was filed on October 31, 2019. Mr. Rhines timely filed a Notice of Appeal on October 31, 2019.

STATEMENT OF THE ISSUES

I. WHETHER THE TRIAL COURT ERRED IN DENYING AN APPLICATION FOR A TEMPORARY RESTRAINING ORDER, PRELIMINARY INJUNCTION, OR STAY OF EXECUTION.

Relevant Law:

SDCL § 23A-27A-32.1

SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984)

State v. Robert, 2012 S.D. 27, ¶ 9, 814 N.W.2d 122 (S.D. 2012)

Losee v. Hettich, 74 S.D. 461, 54 N.W.2d 353 (S.D. 1952)

Hendrickson v. Wagners, Inc., 1999 SD 74, ¶ 14, 598 N.W.2d 507 (S.D. 1999)

II. WHETHER RES JUDICATA APPLIES WHEN AN INDIVIDUAL INVOKES HIS STATUTORY RIGHTS UNDER SDCL 23A-27A-32.1 AND SL 1984, CH 181, BUT THE STATE, FOR THE FIRST TIME, REFUSES TO COMPLY WITH THE GOVERNING STATUTES.

Relevant Law:

SDCL § 23A-27A-32.1

SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984)

State v. Hammerquist, 67 S.D. 417, 293 N.W. 539 (S.D. 1940)

Boever v. S. Dakota Bd. of Accountancy, 526 N.W.2d 747 (S.D. 1995)

Lewton v. McCauley, 460 N.W.2d 728 (S.D. 1990)

Farmer v. S. Dakota Dep't of Revenue & Regulation, 2010 S.D. 35, 781 N.W.2d 655 (S.D. 2010)

III. WHETHER THE STATE IS VIOLATING MR. RHINES'S STATUTORY RIGHT TO BE EXECUTED WITH AN "ULTRA-SHORT-ACTING BARBITURATE" BY USING PENTOBARBITAL, WHICH IS NOT AN ULTRA-SHORT-ACTING BARBITURATE.

Relevant Law:

SDCL § 23A-27A-32.1

SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984)

Smith v. State, No. BDV-2008-303, 2015 WL 5827252 (Mont. Dist. Oct. 6, 2015).

IV. WHETHER THE STATE IS VIOLATING MR. RHINES'S FEDERAL RIGHTS UNDER THE DUE PROCESS CLAUSE TO THE U.S. CONSTITUTION.

Relevant Law:

Bagley v. Rogerson, 5 F.3d 325 (8th Cir. 1993)

Hicks v. Oklahoma, 447 U.S. 343 (1980)

Osloond v. Farrier, 659 N.W.2d 20 (S.D. 2003)

DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189 (1989)

Ohio Adult Parole Auth. v. Woodard, 523 U.S. 272, 289 (1998) (O'Connor, J.)

INTRODUCTION

This case asks the Court to enforce a set of clear statutory commands from the South Dakota legislature. Pursuant to Section 23A-27A-32.1 South Dakota Codified Laws, no less than seven days before a scheduled execution, a death-sentenced inmate who was convicted or sentenced prior to July 1, 2007 is entitled to elect to be executed in the manner set forth in South Dakota law at the time of his conviction or sentence. In 1993, South Dakota law provided that

the punishment of death "shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent…." SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984).

Appellant Charles Russell Rhines was sentenced to death in 1993 and has exercised his right to elect the manner of execution in place at that time, but the State notified him that it would inflict death with pentobarbital, a drug that is neither an "ultra-short-acting barbiturate" nor a chemical paralytic agent. Mr. Rhines therefore brings causes of action that arise out of his statutory rights, his exercise of those rights in accordance with the statutory requirements, and the State's refusal earlier this month to comply with the governing statutes.

The trial court did not reach the merits of this issue, but rather decided that Mr. Rhines's prior habeas litigation that had challenged a prior execution protocol on constitutional grounds likely preclude Mr. Rhines from now enforcing his statutory right. The facts the underlie the basis for the instant claims, however, did not exist at the time of the earlier litigation and only arose after Appellee South Dakota Department of Corrections ("DOC"), in response to Mr. Rhines's timely election and a subsequent letter from his attorneys, informed Mr. Rhines earlier this month that it would not comply with the statutory mandates.

Unlike any prior litigation, Mr. Rhines today seeks to enforce his state statutory rights. Every issue newly arises out of two statutes and an unforeseen event that occurred earlier this month: the State's refusal to comply with those statutes. This Court should grant Mr. Rhines the relief to which he is entitled to by statute: to be executed with an ultra-short-acting barbiturate and a stay to prevent the State from executing him with a drug that is not an ultra-short-acting barbiturate.

PERTINENT FACTUAL AND PROCEDURAL BACKGROUND

Mr. Rhines is a prisoner sentenced to death by the State of South Dakota, with an execution warrant setting his execution week as between November 3, 2019 and November 9, 2019. Mr. Rhines was sentenced to death on January 29, 1993.

Previously, in 2011, Mr. Rhines litigated whether the legislature's amendments to its execution statute in 2007 and the State's August 2011 protocol complied with the Eighth Amendment standards as set forth by the United States Supreme Court in *Baze v. Rees*, 533 U.S. 35 (2008). *See* Feb. 27, 2013, Op., Trimble, J.at 8. Judge Trimble ultimately determined that the protocol was sufficiently like *Baze* that it was constitutional on its face, *id.* at 10–12, and that South Dakota would implement its protocol in a constitutional manner. *Id.* at 12–18.

In 2018, Mr. Rhines challenged the State's creation of a new execution protocol without complying with the Administrative Procedure Act. *See Rhines v. S. Dakota Dep't of Corr.*, 2019 S.D. 59 (S.D. 2019).

Pursuant to Section 23A-27A-32.1 South Dakota Codified Laws, Mr. Rhines is entitled to elect to be executed in the manner set forth in South Dakota law at the time of his conviction or sentence. In 1993, South Dakota law provided that the punishment of death "shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent…." SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984).

As recently as August 2019, the State provided documents to Mr. Rhines's attorneys regarding sodium thiopental, a drug that is classified as an ultra-short-acting barbiturate with which the State could execute Mr. Rhines in compliance with its law. *See, e.g.*, Exhibit attached to 11/1/2019 Affidavit of Timothy Rahn. For example, in a letter dated April 17, 2012, the State wrote to the Food & Drug Administration and indicated that the State possessed sodium

thiopental. *Id.* The State "enclose[ed] the FDA's March 25, 2011, letter authorizing South Dakota's importation of sodium thiopental stock . . . ." *Id.* The State resisted a request from the Food & Drug Administration to "return . . . any foreign-manufactured thiopental . . . ." *Id.*

On October 1, 2019, Mr. Rhines exercised his statutory right to be executed according to the law in effect at the time of his sentence. He sent a Kite-Request Slip to Appellee Darin Young, Warden of the South Dakota State Penitentiary, electing to be executed in the manner that was in effect at the time that he was sentenced to death. In an amended Kite-Request Slip to Warden Young, dated October 4, 2019, Mr. Rhines reiterated his choice to be executed in the manner that was in effect at the time that he was sentenced to death, to wit, "[t]he Two Drug Protocol of a Lethal Dose of An Ultra-Short Acting Barbiturate and a Chemical Paralytic." Warden Young never responded to these requests and never indicated that the DOC would not comply with Mr. Rhines's election.

On October 15, 2019, attorneys for Mr. Rhines, emailed and mailed a letter to Warden Young, Jason R. Ravnsborg in his capacity as the Attorney General for the State of South Dakota, and Paul Swedlund, Assistant Attorney General. Counsel requested confirmation that Mr. Rhines's request to be executed by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent would be honored. In a letter dated October 17, 2019, Assistant Attorney General Swedlund advised counsel that he had received "Mr. Rhines' request for execution pursuant to the combination of drugs provided by statute at the time of his execution." Mr. Swedlund asserted that "State will follow the law." Mr. Swedlund further informed counsel that "[t]he ultra-short-acting barbiturate the state intends to use is pentobarbital."

On October 22, 2019, Rhines filed an action in the Circuit Court for the Second Judicial Circuit seeking injunctive and declaratory relief to enforce his statutory right under South Dakota law to be executed by the manner he chose.

Rhines's Complaint alleges four causes of action. The First Cause of Action, Violation of the Right to Choose the Manner of Execution Provided by Law at the Time of Sentence, alleges that, in enacting SDCL § 23A-27A-32.1, the State of South Dakota created a state statutory right that entitles Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence. (Compl. ¶¶ 39-44.) The manner of execution provided by South Dakota law at the time of Rhines's conviction and sentence was, in relevant part, "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch 181, codified at SDCL § 23A-27A-32 (1984.) Rhines exercised his right to choose the manner set forth in SL 1984, ch 181. (Compl. ¶ 44.) Rhines did so in accordance with the provisions of SDCL § 23A-27A-32.1. (*Id.*)

The Second Cause of Action, Deprivation of Due Process, alleged that in enacting SDCL § 23A-27A-32.1, the State of South Dakota created life and liberty interests that entitle Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence. (Compl. ¶¶ 51-54.) Rhines's life and liberty interests in being executed in this manner are protected by the Due Process Clause of the Fourteenth Amendment of the United States Constitution and the Due Process Clause of Article Six, Section 2 of the South Dakota Constitution. (*Id.* ¶¶ 55-56.)

The Third Cause of Action, Injunctive Relief, and the Fourth Cause of Action, Declaratory Judgment, sought injunctive and declaratory relief: (1) Staying Rhines's execution pending adjudication of this action; (2) declaring that pentobarbital is neither an ultra-short-acting barbiturate nor a chemical paralytic agent; (3) enjoining the State from executing Rhines with pentobarbital; and (4) ordering that the State shall execute Rhines only with an ultra-short-acting barbiturate, to wit, sodium methohexital or sodium thiopental, in combination with a chemical paralytic agent. (*Id.* ¶¶ 58-71.)

In light of Mr. Rhines's scheduled execution, he also filed an application for a preliminary injunction, temporary restraining order, or stay of execution to prohibit the State from executing him with pentobarbital and to order that the State shall execute Rhines only with an ultra-short-acting barbiturate in combination with a chemical paralytic agent. Rhines requested an expedited hearing on his application for a preliminary injunction so that the lower court could rule on the application in advance of the execution week beginning November 3, 2019.

The matter was assigned to Judge Jon C. Sogn who scheduled a hearing for October 29, 2019. Late in the evening of October 27, 2019, Assistant Attorney General Swedlund filed a Response to the Motion for Preliminary Injunction, Temporary Restraining Order, and Stay of Execution.

At the October 29, 2019 hearing, Judge Sogn heard argument from counsel and testimony from Dr. Craig Stevens, Ph.D, a professor of Pharmacology at Oklahoma State University. Dr. Stevens explained that barbiturates are classified as ultra-short-acting, short-acting, intermediate-acting, or long-acting. He is not aware of any peer reviewed articles or medical literature that

has ever classified pentobarbital as an ultra-short-acting barbiturate. He testified that in his expert opinion, pentobarbital is not an ultra-short-acting barbiturate.

Judge Sogn took the matter under advisement. He invited the parties to submit any additional argument, authority, or affidavits by the following afternoon. On October 30, 2019, Mr. Rhines filed a supplemental memorandum and an affidavit from attorney Fritz offering additional medical and pharmacological authority supporting the fact that pentobarbital is not an ultra-short-acting barbiturate.

Mr. Rhines submitted authoritative medical texts and articles that date back to before 1984, when the legislature wrote the statute at issue, that confirm Dr. Stevens's opinion. Mr. Rhines submitted other authorities specific to the field of anesthesiology and outside the field of pharmacology that likewise classify pentobarbital as a short-acting barbiturate. Further, Mr. Rhines directed the court's attention to manufacturers of pentobarbital that refer to it as a short-acting barbiturate.

The State made no additional formal filings, although it sent two short e-mails to Judge Sogn to reiterate one argument and to provide a citation for one additional case.

On October 31, 2019, the Second Judicial Circuit Court denied an application for a temporary restraining order and preliminary injunction, and declined to grant a stay of execution. Mr. Rhines filed a notice of appeal that same day.

In addressing whether Mr. Rhines was likely to succeed on the merits of this case, the trial court did not address whether pentobarbital was classified as an ultra-short-acting barbiturate in compliance with the relevant statute. Instead, the trial court held that Mr. Rhines's claims would likely be barred based upon res judicata. To the contrary, Mr Rhines could not have properly litigated this claim in earlier litigation because, as set forth below, Mr. Rhines's

prior litigation did not seek enforcement of his statutory rights. The trial court also asserted that Mr. Rhines's request for a stay should be denied because he should have litigated this issue earlier. But the statute at issue did not require Mr. Rhines to elect a method of execution until, at the latest, seven days prior to the execution. And Mr. Rhines did not have reason to believe that Appellees would not honor his request: Appellees had represented to Mr. Rhines's attorneys in August of 2019 that they had an ultra-short-acting barbiturate, sodium thiopental, and; the DOC protocol specifically contemplates executions using sodium thiopental.

Mr. Rhines now seeks a stay of execution pending appeal of that denial and files this emergency appeal to this Court.

STANDARD OF REVIEW

This Court reviews a denial of a temporary restraining order, a preliminary injunction, or a stay of execution for abuse of discretion. *Losee v. Hettich,* 74 S.D. 461, 54 N.W.2d 353 (1952). "An abuse of discretion can simply be an error of law or it might denote a discretion exercised to an unjustified purpose, against reason and evidence." *Hendrickson v. Wagners*, Inc., 1999 SD 74, ¶ 14, 598 N.W.2d 507, 511 (S.D. 1999) (citations omitted) (quoting *Knodel v. Kassel Township*, 1998 SD 73, ¶ 6, 581 N.W.2d 504, 506 (S.D. 1998)).

This Court reviews de novo questions of res judicata. *See Farmer v. S. Dakota Dep't of Revenue & Regulation*, 2010 S.D. 35, 781 N.W.2d 655, 659 (S.D. 2010).

This Court has an inherent power to preserve the status quo pending appeal. *Smith v. Reid*, 60 S.D. 128, 132–33, 244 N.W. 81, 83 (1932); *Gamet v. Allender*, 50 S.D. 150, 208 N.W. 782, 783 (1926). The staying of the execution of a condemned inmate comes within this Court's inherent authority to preserve the status quo. *State v. Robert*, 2012 S.D. 27, ¶ 9, 814 N.W.2d 122, 124-25 (S.D. 2012). This power "'should always be exercised when any irremediable

injury may result . . . .'" *Id*. (citing *Merrimack River Sav. Bank v. City of Clay Ctr*., 219 U.S. 527, 534–35, 31 S. Ct. 295, 296, 55 L. Ed. 320 (1911)). Failing to stay an execution "obviously result[s] in an irremediable injury." *State v. Robert*, 2012 S.D. 27, ¶ 9 (S.D. 2012).

ARGUMENT

I. MR. RHINES HAS DEMONSTRATED THE REQUISITE LIKELIHOOD OF SUCCESS ON THE MERITS TO JUSTIFY A STAY.

This action involves important issues regarding SDCL § 23A-27A-32.1, in which the State of South Dakota codified a statutory right that entitles Mr. Rhines to be executed in the manner provided by South Dakota law at the time of his conviction or sentence. In accordance with that statute, Mr. Rhines exercised his right to choose the manner set forth at the time of his sentence: execution by an ultra-short-acting barbiturate in combination with a chemical paralytic. The State then informed Mr. Rhines that it will use pentobarbital to execute him. Pentobarbital, as discussed *infra* Section I.b., is *not* an ultra-short-acting barbiturate or a chemical paralytic, however. By refusing to follow binding law, the DOC is depriving Rhines of his statutory right.

In deciding a stay motion, courts must decide whether a movant showed a likelihood of success on the merits. *See Strong v. Atlas Hydraulics, Inc.*, 2014 S.D. 69, ¶ 12, 855 N.W.2d 133, 139 (S.D. 2014); *Nelson v. Campbell*, 541 U.S. 637, 649-50 (2004). The likelihood of success does not mean that the inmate will probably win, but rather, that the inmate has shown a "significant possibility" of success. *Nooner v. Norris*, 491 F.3d 804, 808 (8th Cir. 2007) (citing *Hill v. McDonough*, 547 U.S. 573, 584 (2006)). Stays are not granted in instances in which the suit "amounts to little more than an attack on settled precedent" or is based on speculative theories. *See Bucklew v. Precythe*, 139 S. Ct. 1112, 1134 (2019).

a. Mr. Rhines Filed His Action Within Three Business Days of When It Presented a Concrete Case or Controversy With Ripe Issues.

In their response, Appellees raised a defense of res judicata. The trial court decided that Mr. Rhines had not demonstrated the requisite likelihood of success on his causes of action in light of that defense. *See* Order at 22. The heart of the trial court's analysis, however, is an erroneous conclusion it repeats throughout its order: that Mr. "Rhines challenged the exact protocol in 2011 [that] he is challenging now." Order at 21. That conclusion misconstrues the nature of Mr. Rhines's prior litigation in 2011 and this suit, and it misapplies the law of res judicata.

Unlike any prior litigation, Mr. Rhines today seeks to enforce his state statutory rights. His causes of action are rooted in SDCL § 23A-27A-32.1 and SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984), not the State's protocol. As discussed below, this case could not have presented any court with a justiciable case or controversy or any ripe issue until the DOC notified Mr. Rhines that it refused to comply with Mr. Rhines's statutory rights under SDCL § 23A-27A-32.1 and SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984).

The doctrine of res judicata bars any "attempt to relitigate a cause of action by the parties or one of the parties in privity to a party to an earlier suit." *Dakota Plains AG Ctr., LLC v. Smithey*, 772 N.W.2d 170, 179–80 (S.D. 2009) (quoting *Speck v. Federal Land Bank of Omaha*, 494 N.W.2d 628, 633 (S.D.1993)). "The doctrine 'embodies both merger and bar [.]'" *Id.*, *Black Hills Jewelry Mfg. Co. v. Felco Jewel Indus., Inc*., 336 N.W.2d 153, 157 (S.D.1983) (citing *Palma v. Powers*, 295 F.Supp. 924 (N.D.Ill.1969)). "'Res judicata serves as claim preclusion to prevent relitigation of an issue actually litigated or which could have been properly raised and determined in a prior action.'" *Id.* (quoting *Black Hills Jewelry Mfg. Co.*, 336 N.W.2d at 157).

Whether an issue could have been properly litigated in an earlier action requires consideration of whether the issue actually had been ripe for determination at the time of that earlier action. *See State v. Hammerquist*, 67 S.D. 417, 293 N.W. 539, 541 (S.D. 1940); *Danforth v. City of Yankton*, 25 N.W.2d 50 (S.D. 1946).

Ripeness involves the timing of judicial review and the principle that the judicial machinery should be conserved for problems that are real and present, not squandered on problems that are abstract, hypothetical, or remote. *Steinmetz v. State, State Star Academy*, 756 N.W.2d 392, 399 (S.D. 2008). For instance, issues that are "dependent upon the future occurrence of conduct and events that were uncertain and unknown" are unripe for judicial determination. *See Boever v. S. Dakota Bd. of Accountancy*, 526 N.W.2d 747, 750 (S.D. 1995). Issues, however, that are "imminent and inevitable" are ripe for review. *Id.* Courts should not render advisory opinions or decide theoretical questions when the future shows no indication of the invasion of a right. *Id.*

Here, as a threshold matter, the trial court misconstrued the nature of Mr. Rhines's causes of action by repeatedly describing them as a "challenge [to] the [execution]s protocol's compliance with the statutes [at issue]," and comparing it to Mr. Rhines's 2011 litigation. *See* Order at 16; *see also id.* at 17 ("Rhines could have and should have brought a specific challenge to the use of pentobarbital as part of his then-pending complaint . . . ."); *id.* at 21 ("Rhines challenged the exact protocol in 2011 as he is challenging it now."). The actual nature of Mr. Rhines's prior litigation and this litigation belie the trial court's analysis.

Earlier, in 2008, Mr. Rhines made constitutional challenges to the State's manner of execution. He sought a ruling that the Eighth Amendment barred "an execution carried out by means of [a] two drug cocktail provided in SDCL 23A-27A-32 in effect at the time of his

conviction" and "a declaration that SDCL 23A-27 A-32, as presently codified, and as applied to Rhines, constitute[d] an unconstitutional bill of attainder[,] an unconstitutional ex post facto law[,] and deprive[d] him of his right to due process of the law." Order at 13. The State adopted a new protocol in 2011, during that litigation, and Judge Trimble later denied relief for all of Mr. Rhines's claims. *See id.* at 13–14. In 2018, Mr. Rhines unsuccessfully challenged the current protocol's promulgation as in violation of the Administrative Procedures Act.

None of those challenges gave Mr. Rhines reason to believe that the State would not use an ultra-short-acting barbiturate if he exercised his statutory right that he seeks to enforce through this litigation. As of October 2019, by statute, Mr. Rhines had the right to elect his method of execution, either by the law currently in place, or by the law in place at the time of his conviction or sentence. The Legislature mandated that he make his election at least seven days prior to his scheduled execution. SDCL § 23A-27A-32.1. There is no dispute that Mr. Rhines complied with the statute governing his election. On October 1, 2019, more than a month before his scheduled execution, Mr. Rhines sent a Kite Request Slip to Darin Young, Warden of the South Dakota State Penitentiary, Mr. Rhines chose to be executed in the manner that was in effect at the time that he was sentenced to death.

Before October 17, 2019, there was no reason to believe that the State would do anything other than abide by the statutory requirement Mr. Rhines had elected, i.e., a lethal dose of an ultra-short acting barbiturate and chemical paralytic agent. The State has possessed an ultra-short-acting barbiturate, sodium thiopental, in the past. Further, the 2011 protocol contemplated the use of sodium thiopental in executions. But the State, on October 17, indicated it would not use sodium thiopental and, instead, advised counsel that "[t]he ultra-short-acting barbiturate the

state intends to use is pentobarbital." As discussed *infra* Section I.b., pentobarbital is not an ultra-short-acting barbiturate.

As a result, Mr. Rhines promptly initiated this new action to enforce his statutory rights *after* DOC notified him that it would violate his statutory rights for the very first time. The causes of action in this case therefore arise out of the State's refusal to comply with Mr. Rhines's proper statutory election and events that culminated in the State's mailing of a letter that it would use a short-acting or intermediate-acting barbiturate, but not an ultra-short-acting one. Any litigation therefore was contingent upon the state notifying Mr. Rhines that it was refusing to comply with the statutes at issue. At no earlier point in time did Mr. Rhines "ha[ve] a 'full and fair opportunity to litigate'" these causes of action, let alone "a controversy in which a claim of right is asserted against one who has an interest in contesting it." Order at 19 (quoting *Boever v. South Dakota Bd. Of Accountancy*, 526 N.W.2d 747, 750 (S.D. 1975). Nor were the issues being litigated here previously "ripe for judicial determination." *Id.* (quoting *Boever*, 526 N.W.2d at 750).

For example, the trial court relied on *Lewton v. McCauley*, 460 N.W.2d 728, 730 (S.D. 1990), and *Farmer v. S. Dakota Dep't of Revenue & Regulation*, 2010 S.D. 35, 781 N.W.2d 655 (S.D. 2010), to apply *res judicata* against Mr. Rhines, but these cases support Mr. Rhines's position that *res judicata* is not implicated here. In *Lewton*¸ this Court found that when facts arise after initial litigation is terminated, and those facts underlie new claims, the doctrine of *res judicata* does not apply. *Letwon*, 460 N.W.2d at 731. If facts "did not exist at the time" of the earlier litigation, *res judicata* cannot be a bar to subsequent litigation. *Id.* By contrast, where a party has "a full and fair opportunity to litigate" its claims in an earlier proceeding, *res judicata*

will apply. *Farmer,* 781 N.W. 2d at 661. This Court cautioned that "we should not" "interpret[] the doctrine of res judicata too broadly[.]" *Lewton,* 460 N.W.2d at 730.

If anything, the State's Notice of Adoption of Revised Execution Policy and Protocol dated October 24, 2011, put Mr. Rhines on notice that the DOC ***would*** comply with the law in effect in 1993 if Mr. Rhines so elected, not that it would disregard the statute's plain language. Specifically, the protocol provided that an inmate "shall be executed using the 3- or 1-Drug protocol provided in this document . . . unless the inmate requests in writing . . . that the inmate wishes to be executed by the 2-Drug protocol set forth herein *in accordance with South Dakota law as it existed* prior to July 1, 2007." State's Exhibit 1 at page 3 (emphasis added). This language *imposes a limitation on* the protocol's application to ensure compliance with statutory law as it existed prior to July 2007, i.e., the 1984 statute in this case. Implementation of the 2-drug protocol "in accordance with South Dakota law" requires the DOC to use an ultra-short-acting barbiturate, like thiopental, which, the protocol provides, is indeed an option for use in the execution. Thus, on the face of the Notice, Mr. Rhines had no reason to believe that, if he elected that option, the DOC would fail to comply with the South Dakota law as it existed prior to July 1, 2007 by using an ultra-short-acting barbiturate, because (1) sodium thiopental was an option in the Notice and (2) it stated that Defendants would follow the pre-2007 law.

Although Mr. Rhines's attorneys made this very point in oral argument, the trial court failed to cite this critical portion of the protocol that imposes a *limitation* on the state. Instead, the trial court quoted only a different portion of that paragraph. *See* Order at 13–14. The trial court erroneously gave weight to the fact that the 2011 protocol "listed pentobarbital as one of two drugs that could be administered in the 2-drug protocol." Order at 17. The protocol also listed thiopental, and did not "contain[] explicit notice of the State's intention to use

pentobarbital . . . ." *See* Order at 16. There would have been no foreseeable, let alone ripe, issue regarding the State's use of pentobarbital unless and until the State indicated it would use that drug on an individual sentenced in 1993 who had elected to be executed in the manner required by law in 1993, thus, that the State would not in fact act "in accordance with South Dakota law [in 1993]."

Similarly, this Court should reject the trial court's reasoning that would have required Mr. Rhines to litigate this issue on the *belief* that the State would violate the law by failing to comply with the 1984 statute. The trial court relied on *Boever*, but the *Boever* Court addressed two issues: (1) a challenge involving a quality reviews mandated by statute to occur every three years and (2) a challenge involving a statute that imposes discipline under certain circumstances. *See Boever v. S. Dakota Bd. of Accountancy*, 526 N.W.2d 747, 749–51 (S.D. 1995). The former challenge was ripe, because the issues were "'*imminent and inevitable*.'" Order at 20–21 (quoting *Boever*, 526 N.W.2d at 750) (emphasis added).

Here, however, the State's use of a drug that would violate the 1984 statute was not "bound to happen." In fact, to apply that analysis here, this Court would have to agree that the DOC's refusal to follow the law was "imminent and inevitable." Such a conclusion requires a degree of skepticism about the DOC's responsibilities that this Court should reject. As noted above, the 2011 protocol's own language demonstrates the DOC's recognition of a need to comply with statutory law. Mr. Rhines's action therefore "was dependent upon the future occurrence of conduct and events that were *uncertain and unknown*," like the "likelihood of future discipline" in *Boever*, and res judicata does not apply. *Id.* at 750.

Moreover, that the DOC included pentobarbital as one of the two possible drugs it would use in its 2011 two-drug protocol is not relevant here. Mr. Rhines is not challenging alternate

possibilities presented in that protocol here. His causes of action arise out of two statutes—SDCL § 23A-27A-32.1 and SDCL § 23A-27A-32.1 and SL 1984, ch 181, codified at SDCL 23A-27A-32 (1984)—and the State's refusal to comply with those statutes, not the State's protocol. The trial court also appears to treat *notice* of *possible* State action as sufficient to confer standing and make the issues in this case ripe, going so far as to conclude that, "[b]ecause the . . . prior litigation specifically talked about both drugs [(pentobarbital and thiopental)], the protocol, and the statute, Rhines was bound to bring the claims at that time." *See* Order at 16 (reasoning that "Rhines was put on notice of the adoption and revision of the protocol."). Yet a State's "talk[ing] about" multiple options does not create a justiciable case or controversy or a make a possible issue ripe for judicial determination.

In fact, as recently as August 2019, the State provided documents to Mr. Rhines's attorneys regarding thiopental, a drug that actually is an ultra-short-acting barbiturate with which the State could execute Mr. Rhines in compliance with state law. *See, e.g.*, Exhibit attached to 11/1/2019 Affidavit of Timothy Rahn. One of those documents is a letter dated April 17, 2012, in which the Office of the Attorney General of South Dakota wrote to the Food & Drug Administration. *See id.* The Attorney General indicated that the State possessed thiopental and "enclose[ed] the FDA's March 25, 2011, letter authorizing South Dakota's importation of sodium thiopental stock . . . ." *Id.* The State resisted a request from the Food & Drug Administration to "return . . . any foreign-manufactured thiopental . . . ." *Id.*

If Appellees were not prepared to comply with statute they could have, at any time, either sought an amendment to SDCL § 23A-27A-32.1 or could have sought relief from the court from compliance with the statute. They did not.

In sum, before October 2019, any issues concerning the State's willingness to follow the law in effect at the time of Mr. Rhines's sentence would have been based on speculation about future actions that may or may not occur. Those issues were not ripe at that time and, thus, res judicata does not bar this action. Accordingly, this Court should reverse the trial court's order and grant Mr. Rhines the relief he seeks: to be executed with an ultra-short-acting barbiturate and a stay to prevent the State from executing him with a drug that is not an ultra-short-acting barbiturate.

b. The Trial Court Fails to Address Mr. Rhines's First Cause of Action, that Appellees Violated His Statutory Rights, A Cause of Action Upon Which Mr. Rhines is Likely to Succeed.

Affirming the trial court's ruling would permit the DOC to violate the plain language of binding statutory law. The trial court did not address this issue, but Mr. Rhines clearly met his burden to justify temporary relief or, in the alternative, final judgment requiring the DOC to comply with the law.

Mr. Rhines is likely to succeed on the merits of his cause of action alleging a violation of state statutory law. The plain language of the statutes at issue is clear. In enacting SDCL § 23A-27A-32.1, the State of South Dakota entitled Rhines to be executed in the manner provided by South Dakota law at the time of his conviction or sentence. *See* SDCL § 23A-27A-32.1.

In the trial court, Rhines relied on the unambiguous language of the execution statute at the time of his conviction and sentence. At the time of his conviction and sentence, the execution statute used the precise term "ultra-short-acting barbiturate" as the necessary first drug in an execution. SL 1984, ch 181, codified at SDCL § 23A-27A-32 (1984). "The intent of a statute is determined from what the legislature *said, rather than what the courts think it should have said,* and the court must confine itself to the language used. Words and phrases in a statute

must be given their plain meaning and effect." *Rhines v. S. Dakota Dep't of Corrs.*, 2019 S.D. 59, ¶ 13 (2019) (emphasis added).

That term "ultra-short-acting barbiturate" had, and continues to have, a clear meaning, as demonstrated by substantial evidence in the record before this Court. Pentobarbital, which the state has indicated it plans to use as an "ultra-short-acting barbiturate," is not classified as an ultra-short-acting barbiturate.

i. The State Is Violating Its Statutory Obligation to Execute Rhines with an Ultra-Short-Acting Barbiturate in Combination with a Chemical Paralytic Agent.

The plain language of the statutes at issue is clear. SDCL § 23A-27A-32.1 entitles Mr. Rhines to be executed in the manner provided by South Dakota law at the time of his sentence. *See* SDCL § 23A-27A-32.1. The South Dakota Legislature enacted this provision in February of 2007 and made no changes to it when the Legislature amended portions of § 23A-27A-32 in 2008.

When Mr. Rhines was convicted and sentenced, in 1993, South Dakota law provided, in pertinent part, and unequivocally, that "[t]he punishment of death *shall* be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch. 181 (emphasis added). The statute allows no discretion in the manner of execution, but rather gives specific directives as to the manner of execution. Accordingly, SDCL § 23A-27A-32.1 and SL 1984, ch. 181, codify a right to an execution "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent." SL 1984, ch. 181.

Pursuant to the SDCL § 23A-27A-32.1, Mr. Rhines shall be executed in this manner if he "choose[s] by indicating in writing to the warden not less than seven days prior to the scheduled week of execution the manner of execution chosen." SDCL § 23A-27A-32.1. Mr. Rhines chose to be executed in this manner—more than 4 weeks prior to the week of his execution—in a written Kite-Request Slip dated October 1, 2019, addressed to Defendant Young, and in an amended written Kite-Request Slip dated October 4, 2019, addressed to Defendant Young. (Compl. ¶¶ 30, 31, Exhibits B, C to the Compl.) Based upon the foregoing, Mr. Rhines has demonstrated that he has a right to be executed in the manner he has chosen arising from South Dakota Codified Law.

The DOC cannot deprive Rhines of his right to be executed in the manner of his choice. The DOC, however, has taken the position that pentobarbital is an ultra-short-acting barbiturate. (Compl. ¶ 34, Exh. E to the Compl.) The DOC's assertion is erroneous and contradicted by substantial record evidence, as discussed in more detail below. Pentobarbital is not an ultra-short-acting barbiturate. (Compl. ¶ 36; Stevens Aff. ¶¶ 7, 8.) Ultra-short-acting barbiturates include sodium methohexital and sodium thiopental. (Compl. ¶ 35; Stevens Aff. ¶ 7.) The statute's plain language requires that the State use an ultra-short-acting barbiturate. By refusing to guarantee that Rhines will be executed in the manner set forth in SL 1984, ch. 181, the State is depriving Rhines of his state statutory right codified and protected by SDCL § 23A-27A-32.1, and SL 1984, ch. 181.

This case is analogous to *Smith v. State*, No. BDV-2008-303, 2015 WL 5827252 (Mont. Dist. Oct. 6, 2015) (Exh. A to the Compl.). In *Smith*, the Court addressed a similar Montana law that provided "[t]he punishment of death must be inflicted by administration of a continuous, intravenous injection of a lethal quantity of an ultra-fast-acting barbiturate in combination with a

chemical paralytic agent until a coroner or deputy coroner pronounces that the defendant is dead." *Id.* at *1. However, the State of Montana intended to execute Smith using pentobarbital, which, Smith argued, is not an ultra-fast-acting barbiturate. *Id.* After a trial, the court concluded, among other things, that pentobarbital is not an ultra-fast-acting barbiturate and enjoined the State of Montana from executing Smith using pentobarbital. *Id.* at *6. The court credited the fact that "the terms ultra-fast and ultra-short refer to the same type of barbiturates, as do the terms fast and short, and as do the terms slow and long." *Id.* at *3.

The Montana statute at issue in *Smith* and SL 1984, ch. 181, are nearly verbatim. The evidence presented by Mr. Rhines demonstrates, as was demonstrated in *Smith*, that pentobarbital is not an ultra-short-acting barbiturate. Thus, just as Smith succeeded on the merits of his claims, Mr. Rhines is likely to succeed on the merits of his.

ii. Overwhelming Evidence Confirms that Pentobarbital Is Not an Ultra-Short-Acting Barbiturate.

The evidence presented at the hearing overwhelmingly shows that pentobarbital is not an ultra-short-acting barbiturate. Dr. Craig Stevens, a professor of pharmacology at Oklahoma State University, testified and explained that barbiturates are classified as either ultra-short-acting, short-acting, intermediate-acting, or long-acting, depending upon their chemical properties. The relevant property is lipid solubility. The most lipid-soluble barbiturates are sodium thiopental and methohexital, which are thus classified in the literature as ultra-short-acting. Pentobarbital is less lipid-soluble than sodium thiopental and methohexital to a significant degree and is classified as a short-acting barbiturate.

Barbiturates' lipid solubility does not change depending upon the dose or setting. Dr. Stevens is not aware of any peer-reviewed articles or medical literature that has ever classified

pentobarbital as an ultra-short-acting barbiturate. He testified unequivocally that pentobarbital is not classified as an ultra-short-acting barbiturate.

Dr. Stevens's opinion is consistent with authoritative medical texts and articles that date back to before 1984, when the legislature wrote the statute at issue. *See, e.g.*, Linda Lilley, et al., Pharmacology and the Nursing Process 189 (9th ed. 2020) (including classification chart listing thiopental as ultrashort-acting barbiturate and pentobarbital as short-acting barbiturate); PHARMACOLOGY 111 fig. 9.7 (Richard A. Harvey & Pamela C. Champe eds.) (4th ed. 2009) (classifying pentobarbital as short-acting and thiopental as ultra-short-acting); Carl Burtis, et al., Tietz Textbook of Clinical Chemistry and Molecular Diagnostics 1325-26 & Table 34.10 (4th ed. 2006) (identifying thiopental as ultrashort-acting barbiturate and pentobarbital as short-acting barbiturate); Francisco López-Muñoz, et al., The History of Barbiturates a Century After Their Clinical Introduction, NEUROPSYCHIATRIC DISEASE AND TREATMENT, Vol. 1(4), 329-43, Table 3 (Dec. 2005) (reproducing table from 1983 classifying pentobarbital as short-acting and thiopental as ultrashort-acting); *see also* 1 Lawyers' Guide to Medical Proof § 106.02 (2019) (listing ultrashort-acting barbiturates "in current medical use" as methohexital, thiamylal, and thiopental, and listing pentobarbital among the short-acting and intermediate-acting barbiturates); 9 Attorneys Textbook of Medicine (Third Edition) P. 51.10 (2019) (listing ultrashort-acting barbiturates as thiopental, thiamylal and methohexital); 12-256-9A Courtroom Medicine Series: Psychic Injuries § 9A.50 ("Ultra-short-acting barbiturates include thiopental (half-life of 6 to 46 hours; Schedule III) and methohexital (1 to 2 hours; Schedule IV); the short-acting group includes pentobarbital (Nembutol; 15 to 48 hours; Schedule II; III) . . . .").

The affidavit of Dr. Antognini, submitted by the State, does not contradict this. While it suggests that the duration of pentobarbital's effects changes with a larger dose, he significantly

omits any conclusion that pentobarbital is or has ever been classified as an ultra-short-acting barbiturate. Moreover, courts have found that Dr. Antognini's opinions in the death penalty context are "shown to be an outlier in the field of anesthesiology." *In re Ohio Execution Protocol Litigation*, 2019 WL 244488 at * 62 (S.D. Oh. January 14, 2019) (slip opinion). Appellees were provided with an opportunity to provide a supplemental affidavit to contradict Dr. Stevens testimony, and Appellees failed to do so.

At the hearing, the State asserted that the fact that pentobarbital is sometimes classified as short-acting or intermediate-acting is proof that classifications can change. This assertion only stands for the idea that pentobarbital falls in the middle range. It does not mean, and the State failed to submit any evidence to support a conclusion, that the classification of pentobarbital has ever been ultra-short-acting. The classification of barbiturates as "ultra-short-acting" is the only issue to which the legislature has directed the State and this Court.

The State also suggested—without any evidence—that anesthesiologists do not categorize barbiturates in the same manner as pharmacologists do. To the contrary, the court in *Smith*, cites Margaret Wood and Alistair J.J. Wood's text, I (2d. ed.,Williams & Wilkins 1989), in support of the statement that "[b]arbiturates are traditionally classified as long-acting (phenobarbital), medium-acting (such as pentobarbital), short-acting (secobarbital), and ultra-short-acting (thiopental)." *Smith*, 2015 WL 5827252, at *2. The State has cited an article on neurosurgical anesthesia to support its argument, *see* Response Mot. Prelim. Inj. 14, but that article itself recognizes that pentobarbital is not an ultra-short-acting barbiturate: "[L]ittle is known about the hemodynamic effects of pentobarbital in humans, at least when given in the doses needed for neurosurgical purposes. *This contrasts with the large body of data concerning the effects of the ultrashort-acting anesthetic barbiturates such as thiopental*."). Todd,

Drummond and Sang, Hemodynamic Effects of High Dose Pentobarbital: Studies in Elective Neurosurgical Patients, 20 NEUROSURGERY 559 (1987) (emphasis added).

Other authorities specific to the field of anesthesiology and outside the field of pharmacology likewise classify pentobarbital as a short-acting barbiturate. *See, e.g.*, Helen Lamb, The barbiturates: with particular reference to their use in anesthesia. Bulletin of the American Association of Nurse Anesthetists. 1943;12(4): 228-29 (identifying pentobarbital as a barbiturate "of moderate duration" while identifying evipal, pentothal, and thio-ethymal as "ultra-short-acting barbiturates"); Torben Seear, Pentobarbital Anesthesia in Labor, M.D. American Journal Of Obstetrics And Gynecology, Vol. 99, Issue 7, p. 955 (Dec. 1967) ("Pentobarbital is a short-acting, but not ultrashort-acting barbiturate."); Bryson, Peter D. *Comprehensive Review in Toxicology for Emergency Clinicians* 464 (3d. ed. 1996) (classifying Pentobarbital in the "Short – and Intermediate-acting" Barbiturate classification as opposed to the "Ultrashort-acting" classification); Sandra J. Cunningham & Waseem Hafeez, "Procedural Sedation and Pain Management Techniques," Textbook of Pediatric Emergency Procedures 423 (Christopher King & Fred M. Henretig eds., 2d ed. 2008) (identifying pentobarbital as "a short-acting barbiturate," as opposed to methohexital which is an "ultrashort-acting barbiturate").

Further, manufacturers of pentobarbital refer to it as a short-acting barbiturate. Not only does the FDA-approved branded manufacturer's insert for Nembutal Sodium Solution, which is the manufacturer's name for pentobarbital, state: "NEMBUTAL Sodium is a short-acting barbiturate," (Fritz Exh. 4), but the manufacturers for generic pentobarbital, Sagent and Leucadia, similarly state that pentobarbital is a short-acting barbiturate. *See* https://www.sagentpharma.com/wp-content/uploads/2017/11/Pentobarbital_PI-Revised.pdf; http://leucadiapharma.com/wp-content/uploads/2018/02/Pentobarbital_PI_Art_Clean.pdf.

The State repeatedly mischaracterized testimony on the classification of barbiturates from a different expert, Dr. Mark Heath, in different litigation. Dr. Heath's testimony supports Rhines's position. Dr. Heath used the terms "ultra-short" and "ultra-fast" interchangeably, and he consistently referred to that category of barbiturates in "*contrast*" with pentobarbital. *Compare* State's Exhibit 8 at transcript page 21–22 ("I'll just start by comparing ultra-short and ultra-fast-acting barbiturates which will enter the brain very quickly in a matter of tenths of seconds, and will also leave the brain very quickly . . . . and those drugs would be the class of drug would be thiopental, for example, and another would be a drug called methohexital.") *with id.* at transcript page 22 ("*By contrast*, pentobarbital is slower to take effect and lasts for longer." (emphasis added)).

The State pulled quotations out of context, but even these quotations never established that this different expert classified pentobarbital as "ultra-short-acting." *See, e.g.*, State's Exhibit 11 at transcript page 90 (explaining that the line dividing ultrafast from fast-acting barbiturates "is really a molecular line. . . . . [Molecular] modifications have created a class unto itself."). The State goes so far as to repeatedly cite the expert's testimony in *Smith*, the very premise of which was that pentobarbital is not an ultra-short-acting barbiturate. Thus, that there are "different ways" to classify barbiturates does not change that Dr. Heath never placed pentobarbital in any sort of "ultra-short" or "ultra-fast" category. *See* State's Exhibit 8 at transcript page 21.

Consistent with this evidence, numerous cases have recognized that pentobarbital is not classified as an ultra-short-acting barbiturate. *See McGehee v. Texas Dep't of Criminal Justice*, No. MC H-18-1546, 2018 WL 3996956, at *2 (S.D. Tex. Aug. 21, 2018) ("Testimony in other cases has established that pentobarbital is 'not classified as an ultra-short-acting barbiturate.' *Mann v. Palmer*, 713 F.3d 1306, 1313 (11th Cir. 2013)."); *Bible v. Davis*, No. 4:18-CV-1893,

2018 WL 3068804, at *1 (S.D. Tex. June 21, 2018) ("Pentobarbital is an intermediate-acting barbiturate") (internal quotation omitted), aff'd, 739 F. App'x 766 (5th Cir. 2018); *West v. Schofield*, 519 S.W.3d 550, 553 (Tenn. 2017) (stating that pentobarbital is "described in [Tennessee's execution] Protocol as 'an intermediate-acting barbiturate'") (internal brackets omitted); *Grayson v. Warden, Comm'r, Alabama State*, 869 F.3d 1204, 1210 (11th Cir. 2017) (describing "pentobarbital, [as] a short-acting barbiturate sedative") (internal quotation marks omitted); *West v. Warden, Comm'r, Alabama State*, 869 F.3d 1289, 1292 (11th Cir. 2017) (describing "pentobarbital, [as] a short-acting barbiturate sedative") (internal quotation marks omitted); *Whitaker v. Livingston*, No. CV H-13-2901, 2016 WL 3199532, at *1 (S.D. Tex. June 6, 2016) ("Pentobarbital is an intermediate-acting barbiturate."), *aff'd sub nom. Whitaker v. Collier*, 862 F.3d 490 (5th Cir. 2017); *Smith v. Montana*, No. BDV-2008-303, 2015 WL 5827252, *2 (Oct. 6, 2015) ("Barbiturates are traditionally classified as long-acting (phenobarbital), medium-acting (such as pentobarbital), short-acting (secobarbital), and ultra-short-acting (thiopental).") (Exh. A to the Compl.); *Trottie v. Livingston*, No. CV 4:14-2550, 2014 WL 12527181, at *2 (S.D. Tex. Sept. 5, 2014) ("pentobarbital . . . is an intermediate-acting barbiturate.") (internal quotation omitted); *Arthur v. Thomas*, 974 F. Supp. 2d 1340, 1345 (M.D. Ala. 2013) ("Sodium thiopental is classified as an 'ultra-short acting barbiturate,' while pentobarbital is an 'intermediate-acting barbiturate.' As these classifications indicate, sodium thiopental has an extremely rapid onset of effect and subsequent recovery, while pentobarbital is slower and longer-acting."); *Arthur v. Thomas*, 674 F.3d 1257, 1274 (11th Cir. 2012) ("sodium thiopental is 'ultrashort-acting,' while pentobarbital is 'intermediate-acting'") (internal quotation and citation omitted); *Powell v. Thomas*, 643 F.3d 1300, 1304 (11th Cir. 2011) ("sodium thiopental is 'ultrashort-acting,' while pentobarbital is 'intermediate-acting'") (internal quotation

and citation omitted); *In re Jacoby Airplane Crash Litig*., No. CIV.99-6073 (HAA), 2007 WL 5037683, at *22 (D.N.J. Aug. 27, 2007) ("The ultrashort-acting barbiturates produce anesthesia within about one minute after intravenous administration.... Barbiturate abusers prefer the Schedule II short-acting and intermediate-acting barbiturates that include amobarbital (Amyta®), pentobarbital (Nembutal®), secobarbital (Seconal®), and Tuinal (an amobarbital/secobarbital combination product).") (internal quotation and citation omitted). Nearly all of these cases arose in the lethal injection context thus belying the State's suggestion that pentobarbital's classification changes to ultra-short-acting when it is used in lethal doses for execution.

The State cited cases that, it claimed, indicate the absence of a difference between sodium thiopental and pentobarbital. As described during the hearing, those cases arose in the context of Eighth-Amendment or constitutional challenges focused on various execution protocols' likelihood to produce unnecessary suffering. Not one of these cases states that pentobarbital ever has been classified as an ultra-short-acting barbiturate, the only issue before this Court. In fact, undersigned counsel is aware of no case that identifies pentobarbital as an ultra-short-acting barbiturate.

The legislature used plain language in the statutes at issue. The DOC must follow that language. Just as the *Smith* court held, had the legislature intended to give the State of South Dakota latitude in what drugs to use, it could have used much more general language in the statute authorizing execution. Instead of "ultra-short-acting barbiturate," the legislature could have said "intermediate- or short-acting barbiturates in doses that have the effect of ultra-short-acting barbiturates." Indeed, it later amended the statute to read "a substance or substances in a lethal quantity." SDCL 23A-27A-32.

Courts may not legislate through judicial interpretation of statutes, and this Court should grant a stay of execution to correct the trial court's error and ensure that the DOC follows the clear mandate of the legislature.

The State's assertion that the legislature intended to use the term "ultra-short-acting barbiturate" as "limited to its properties as a lethal agent" has no basis in the text of the statute. It amounts to post hoc speculation by the State to justify its choice of pentobarbital.

Three additional reasons undermine the State's attempt to legislate through this Court. First, if the State's interpretation were correct, it would render meaningless the legislature's subsequent decision to remove the phrase "ultra-short-acting barbiturate" and replace it with "substance or substances in a lethal quantity." *See* SDCL 23A-27A-32. Second, even before 1984, the term ultra-short-acting barbiturate had a well-known and well-defined meaning that did not include pentobarbital. Francisco López-Muñoz, et al., The History of Barbiturates a Century After Their Clinical Introduction, NEUROPSYCHIATRIC DISEASE AND TREATMENT, Vol. 1(4), 329-43, Table 3 (Dec. 2005) (reproducing table from 1983 classifying pentobarbital as short-acting and thiopental as ultrashort-acting). Third, the statute expressly references "standards of medical practice," indicating that it did not legislature in a vacuum, let alone the State's speculative "lethal agent" vaccum. *See* SL 1984, ch. 181, codified at SDCL § 23A-27A-32 (1984). ("The punishment of death shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice.").

c. The Trial Court's Failure to Adjudicate the Merits of Mr. Rhines's Due Process Claim and its Improper Application of Res Judicata to Deny an Injunction or a Stay Denied Mr. Rhines Due Process Under the US Constitution.

The lower court's failure to adjudicate the merits of his due process claim and its improper application of res judicata to deny an injunction or a stay likewise denied due process guaranteed by the Fourteenth Amendment of the U.S. Constitution. At its core, the Due Process Clause guarantees a party not only "the opportunity to present his case," but also the right "to have its merits fairly judged." *Logan v. Zimmerman Brush Co*., 455 U.S. 422, 433 (1982). Thus, to satisfy due process, a hearing must fairly and reliably establish all the facts that the relevant law requires before a person may be deprived of his life and liberty. *See Bell v. Burson*, 402 U.S. 535, 542 (1971).

In *Fayerweather v. Ritch*, 195 U.S. 276, 307 (1904), the Court held that, as a matter of due process, no court may preclude a party from litigating an issue that had not been actually decided in a prior adjudication. The Court also confirmed that when evidence has been "offered at [a] prior trial upon several distinct issues, the decision of any one of which would justify the verdict or judgment, then the conclusion must be that the prior decision is not an adjudication upon any particular issue or issues, and the plea of res judicata must fail." *Id*. at 307.

Here, the lower court's ruling had the same effect. Its improper denial of a temporary injunction or stay without addressing the merits denied due process.

d. The Trial Court Failed to Address Mr. Rhine's Second Cause of Action, that Appellees Deprived Mr. Rhines of His Life and Liberty Interests Protected by the Due Process Clause of the U.S. Constitution and the South Dakota Constitution, A Cause of Action Upon Which Mr. Rhines is Likely to Succeed.

Mr. Rhines is likely to succeed on the merits of his cause of action alleging deprivation of due process. "Procedural due process constrains government decisions 'which deprive individuals of 'liberty' or 'property' interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment.'" *Kroupa v. Nielsen*, 731 F.3d 813, 818 (8th Cir. 2013) (quoting *Mathews v. Eldridge*, 424 U.S. 319, 332 (1976)). "'To establish a procedural due process violation, a plaintiff must demonstrate that he has a protected property or liberty interest at stake and that he was deprived of that interest without due process of law.'" *Osloond v. Farrier,* 659 N.W.2d 20, 24 (S.D. 2003) (quoting *Hopkins v. Saunders*, 199 F.3d 968, 975 (8th Cir. 1999) (citation omitted)). "[S]tate law may create a 'liberty interest' protected by the Fourteenth Amendment… [i]f, for example, a state statute gives 'specific directives to the decision maker that if the [statute's] substantive predicates are present, a particular outcome must follow,' a 'liberty interest' protected by the Fourteenth Amendment is created." *Bagley v. Rogerson,* 5 F.3d 325, 328 (8th Cir. 1993) (quoting *Kentucky Department of Corrections v. Thompson*, 490 U.S. 454, 463 (1989)); *see Hicks v. Oklahoma*, 447 U.S. 343, 346 (1980) (Oklahoma statute providing jury could impose a sentence of no fewer than 10 years in prison created a liberty interest protected by the 14th Amendment in defendant having the jury apply that sentence). To constitute a due process violation, the individual must have been deprived of this right by a state actor. *See Osloond v. Farrier,* 659 N.W.2d 20, 24 (S.D. 2003)*; DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 195, (1989).

After the State enacted SDCL § 23A-27A-32.1, Mr. Rhines had life and liberty interests that entitle him to be executed in the manner provided by South Dakota law at the time of his conviction or sentence. *See* SDCL § 23A-27A-32.1; *Ohio Adult Parole Auth. v. Woodard,* 523 U.S. 272, 289 (1998) (O'Connor, J.) ("A prisoner under a death sentence remains a living person

and consequently has an interest in his life."). Here, in enacting SDCL § 23A-27A-32.1, the State of South Dakota created life and liberty interests that entitle Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence. *See* SDCL § 23A-27A-32.1. The South Dakota Legislature enacted this provision in February of 2007 and made no changes to it when the Legislature amended portions of § 23A-27A-32 in 2008.

At the time that Rhines was convicted and sentenced, in 1993, South Dakota law provided, in pertinent part, and unequivocally, that "[t]he punishment of death ***shall*** be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch.181 (emphasis added). The statute allows no discretion in the manner of execution, but rather gives specific directives as to the manner of execution. *See Bagley,* 5 F.3d at 328. Accordingly, SDCL § 23A-27A-32.1 and SL 1984, ch.181 create protected life and liberty interests in execution "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch.181.

As set forth in Secion I, *supra*, South Dakota Codified Law mandates that Rhines shall be executed in this manner if he chooses it more than seven days before his execution week, which he did. (Compl. ¶¶ 30, 31, Exhibits B, C to the Compl.) Based upon the foregoing, Rhines has demonstrated that he has protected life and liberty interests in being executed in the manner he has chosen arising from South Dakota Codified Law. *See Osloond*, 659 N.W.2d at 24.

The State cannot deprive Rhines of his life and liberty interests without due process of law to which he is entitled under the due process clauses of the Fourteenth Amendment of the United States Constitution and Article Six, Section 2 of the South Dakota Constitution. *See* U.S. Const. amend. XIV, § 1; S.D. Const. art. XI, § 2. Pentobarbital is neither an ultra-short-acting barbiturate nor a chemical paralytic. (Compl ¶ 36; Stevens Aff. ¶¶ 7, 8, 11.) Ultra-short-acting barbiturates include sodium methohexital and sodium thiopental. (Compl ¶ 35; Stevens Aff. ¶ 7.) By stating that Rhines will be executed using pentobarbital, which is not an ultra-short-acting barbiturate, the State is deliberately and intentionally depriving Rhines of his constitutionally protected life and liberty interests without due process of law. Based upon the foregoing, Rhines is likely to succeed on the merits of his Second Cause of Action.

The lower court's failure to adjudicate the merits of his due process claim and its improper application of res judicata to deny an injunction or a stay likewise denied due process guaranteed by the Fourteenth Amendment of the U.S. Constitution. At its core, the Due Process Clause guarantees a party not only "the opportunity to present his case," but also the right "to have its merits fairly judged." *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 433 (1982). Thus, to satisfy due process, a hearing must fairly and reliably establish all the facts that the relevant law requires before a person may be deprived of his life and liberty. *See Bell v. Burson*, 402 U.S. 535, 542 (1971). The lower court's improper denial of a temporary injunction or stay without addressing the merits did not comport with these principles.

II. THIS COURT HAS THE AUTHORITY TO STAY RHINES'S EXECUTION AND SHOULD EXERCISE IT HERE TO AVOID IRREMEDIABLE INJURY TO RHINES.

The Court should exercise its authority to stay Rhines's execution. If Mr. Rhines is executed pursuant to a procedure that does not accord with the law, it is axiomatic that the harm

he will suffer is irreparable, because he will be dead. As the U.S. Supreme Court has recognized, "'[d]eath is a punishment different from all other sanctions in kind rather than degree." *Woodson v. North Carolina*, 428 U.S. 280, 303–04 (1976).

The trial court erred when it concluded that the irreparable harm prong neither favored Mr. Rhines nor the State. The harm Mr. Rhines seeks to avoid is an execution that violates the law that applies to his sentence. Rather than assessing the irreparability of the harm, the court simply summarized the State's arguments on the merits, which are irrelevant to this prong. *See supra* Section I.

Rhines's death by execution is an irremediable injury that should be avoided until this Court rules on whether the State's use of pentobarbital complies with Rhines's statutory rights under South Dakota law. If the State is permitted to execute Rhines using pentobarbital before this issue is decided, Mr. Rhines will be deprived of his statutory right without any possible remedy. Therefore, this Motion for Stay of Execution should be granted.

III. THE BALANCE OF THE EQUITIES FAVORS A STAY.

In balancing the equities, the court reasoned that the DOC has "a strong interest in enforcing its criminal judgments," *see* Order at 10 (citing *Hill v. McDonough*, 547 U.S. 573, 584 (2006), and that there is a "strong equitable presumption" against stays where claims could have been brought earlier," *see* Order at 10–11 (quoting *Nelson v. Campbell*, 541 U.S. 637, 650 (2004)). *See also* Order at 11 (citing *Ledford v. Comm'r, Georgia Dep't of Corr.*, 856 F.3d 1312, 1319–20 (11th Cir. 2017); *Jones v. Allen*, 485 F.3d 635, 640 (11th Cir. 2007)).

As discussed *supra* Section I.a., Mr. Rhines could not have raised his issues earlier, has not delayed, and had no reason to think he needed to raise these issues earlier. Further, he had no reason to believe that he had a need to raise it. Appellees indicated in the 2011 protocol that they

could use sodium thiopental if he elected the 2-drug protocol in effect at the that he was sentenced. Even as late as August of 2019 Appellees provided his counsel with information that suggested they possessed sodium thiopental. Mr. Rhines made his election in a timely manner and filed this suit promptly after the State, for the first time, notified him that it would violate the law.

Each of the federal cases cited by the trial court are inapposite. The petitioners in each case waited years after their claims were ripe before they filed suit. *See Hill*, 547 U.S. at 576–77; *Nelson*, 541 U.S. at 649; *Ledford*, 856 F.3d at 1315–16; *Jones*, 485 F.3d at 638–39. By contrast, Mr. Rhines filed a timely suit, shortly after his cause of action became ripe, and only after the state put him on notice, for the very first time, that it would violate the law. Neither the delay nor the piecemeal litigation at issue in *McGehee v. Hutchinson*, 854 F.3d 488, 492 (8th Cir. 2017), is applicable to this current litigation. In *McGehee*, the petitioners filed suit in state court challenging the 2015 adoption of a method of execution under both the state and federal constitutions. *Id.* at 491. When the state removed to federal court, the petitioners voluntarily dismissed the case and filed a new action in state court, omitting the federal constitutional claim. *Id.* Only after losing the state constitutional challenge, and just three weeks before the first of eight executions scheduled in March 2017, the petitioners again brought a federal constitutional challenge to the 2015. *Id.*

Moreover, the Eighth Amendment challenges raised in each of these cases related to the amount of suffering the petitioners would experience when executed, not whether the execution was, itself, in violation of state law. Mr. Rhines's challenge, by contrast, seeks only to secure his right to be executed in accordance with the very statute that empowers the State to take his life. *Cf. Ericksen v. City of Sioux Falls*, 14 N.W.2d 89, 95 (S.D. 1944) (reasoning that a city "has no

inherent powers and none of the attributes of sovereignty" and "possesses only such powers, great or small, as [the Constitution and statutes of the state] give it").

The State seeks to carry out the most solemn and irrevocable act of government without compliance with the statute that alone authorizes the DOC to take such an act. Any potential inconvenience of using the mandated drug does not counterbalance the harm that Mr. Rhines will suffer when he is executed in violation of the law, or the public interest in knowing that the DOC is conducting executions that are contrary to the authority granted to them by state statutes carefully outlined by its legislators.

IV. THE PUBLIC INTEREST FAVORS A STAY AND COMPLIANCE WITH THE STATUTES AT ISSUE.

As the trial court itself recognized, "[t]he public has a strong interest in making sure the State complies with laws passed by our legislature." Order at 11. "This interest is magnified when the State is carrying out the ultimate criminal penalty—death." Order at 11–12.

CONCLUSION

Mr. Rhines has met the requirements of a stay of execution and for this Court to reverse the trial court's order. For all the reasons set forth above, Mr. Rhines respectfully requests that the Court grant a stay of execution and issue a temporary restraining order, ordering that: (1) pentobarbital is neither an ultra-short-acting barbiturate nor a chemical paralytic agent; (2) the DOC is enjoined from executing Mr. Rhines with pentobarbital, and (3) the DOC shall execute Mr. Rhines only with an ultra-short-acting barbiturate (such as sodium methohexital or sodium thiopental) in combination with a chemical paralytic agent. In the alternative, Rhines requests an expedited hearing and a determination of the merits of his causes of action.

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CERTIFICATE PURSUANT TO SDCL 15-26A-66 and 15-26A-14

I, Daniel R. Fritz, hereby certify that the *Appellant's Brief* in the above-entitled matter complies with the typeface specifications of SDCL § 15-26A-66 and the length specifications in SDCL § 15-26A-14. The *Appellant's Brief* contains 62,523 characters not including spaces or 11, 854 words and that said *Appellant's Brief* does not exceed thirty-two (32) pages and was typed in Times New Roman font, 12 point.

Ballard Spahr LLP

/s/ Timothy R. Rahn

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on November 1, 2019, two (2) true and correct copies of the foregoing *Motion for Stay of Execution* were served by prepaid U.S. Mail and electronic mail upon the following:

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STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	:SS	
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

CHARLES RUSSELL RHINES, Plaintiff, vs. **SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, SECRETARY, SOUTH DAKOTA DEPARTMENT OF CORRECTIONS,** and **DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY,** Defendants.	49CIV19-002940 **MEMORANDUM OPINION AND ORDER DENYING APPLICATION FOR PRELIMINARY INJUNCTION AND STAY OF EXECUTION**

Plaintiff Charles Rhines (Rhines) is scheduled to be executed by lethal injection sometime between November 3-9, 2019, for the murder of Donnivan Schaeffer. Rhines seeks a preliminary injunction and stay of the execution for such duration as necessary to have a full trial on the merits of his complaint alleging that the proposed drug the State intends to use in the lethal injection process, pentobarbital, is not an "ultra-short-acting" barbiturate as required by South Dakota statutes. The State opposes the request, asserting Rhines' claims are barred by res judicata and further that pentobarbital is an ultra-short acting barbiturate as that phrase is used in the statute. The matter came before the Court for hearing on October 29, 2019.

After considering the parties' written submissions, testimony presented at the hearing, the applicable authorities, the record, and oral arguments, the Court denies Rhines' request for a preliminary injunction and stay of execution.

FACTUAL BACKGROUND

On March 8, 1992, the body of Donnivan Schaeffer, an employee of Dig 'Em Donuts in Rapid City, South Dakota, was found in the storeroom of the donut shop. His hands were bound, and he had stab wounds to his abdomen, upper back, and the back of his neck. There was also money missing from the store.

After an investigation, Charles Rhines was charged with third-degree burglary of the store and first-degree murder of Mr. Schaeffer.

A jury trial was held, and on January 22, 1993, the jury found Rhines guilty of these crimes. The jury recommended a sentence of death for the first-degree murder conviction. The trial court entered a judgment and issued a warrant of execution.

Rhines appealed the conviction and sentence to the South Dakota Supreme Court. The South Dakota Supreme Court affirmed the conviction and sentence in an opinion that was issued May 15, 1996. *State v. Rhines, 1996* S.D. 55, 548 N.W.2d 415.

Since that time Rhines has pursued a multitude of suits and appeals, both in the South Dakota state court system, and in the federal court system, including a case in which a decision was issued October 25, 2019, by the South Dakota Supreme Court affirming the dismissal of Rhines' suit challenging a Department of Corrections administrative policy relating to the methods and procedures for carrying out capital

sentences. *Rhines v. South Dakota Department of Corrections*, 2019 S.D. 59, ___ N.W.2d ____.

Rhines is currently scheduled for execution sometime during the week of November 3-9, 2019.

Rhines' request for relief in this case arises out of the South Dakota Legislature's 2007 revisions to South Dakota's death penalty statutes contained in South Dakota Codified Laws Chapters 23A-27A. Prior to the 2007 changes, SDCL 23A-27A-32 read in applicable part:

> The punishment of death shall be inflicted by the intravenous administration of a lethal quantity of an **ultra-short-acting barbiturate** in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice. (*emphasis added*).

The 2007 revisions changed the statute to read in applicable part:

> The punishment of death shall be inflicted by the intravenous injection of a substance or substances in a lethal quantity. The warden, subject to the approval of the secretary of corrections, shall determine the substances and the quantity of substances used for the punishment of death.

At the same time SDCL 23A-27A-32 was revised in 2007, the legislature added a new section, 23A-27A-32.1, which states:

> Any person convicted of a capital offense or sentenced to death prior to July 1, 2007 may choose to be executed in a manner provided in § 23A-27A-32 or in the manner provided by South Dakota law at the time of the person's conviction or sentence. The person shall choose by indicating in writing to the warden not less than seven days prior to the scheduled week of execution the manner of execution chosen. If the person fails or refuses to choose in the time provided under this section, then the person shall be executed as provided in 23A-27A-32.

On October 1, 2019, pursuant to SDCL 23A-27A-32.1, Rhines submitted a "KITE-REQUEST SLIP" addressed to Warden Darin Young in which Rhines elected the method of execution that was in effect at the time that he was sentenced to death. On October 4, 2019, an amended "KITE-REQUEST SLIP" was submitted by Rhines, again addressed to Warden Young, in which Rhines elected the method of execution that was in effect at the time he was sentenced to death, clarifying that the chosen method was pursuant to the two-drug protocol of a lethal dose of an ultra-short-acting barbiturate and chemical paralytic.

On October 15, 2019, attorneys for Rhines sent a letter by e-mail to Warden Young and the Attorney General requesting confirmation that Rhines' requests to be executed by the intravenous administration of a lethal quantity of an ultra-short acting barbiturate would be honored. Rhines' attorneys also requested that the State identify which ultra-short- acting barbiturate would be used to execute Rhines.

Two days later, October 17, 2019, Assistant Attorney General Paul Swedlund, on behalf of the State, sent an e-mail to Rhines' attorneys, stating:

> I am in receipt of your letter regarding Mr. Rhines' request for execution pursuant to the combination of drugs provided by statute at the time of his execution. The DOC will follow the law. The ultra-short-acting barbiturate the State intends to use is pentobarbital.

Five days later, October 22, 2019, Rhines filed this suit against Defendants (hereinafter collectively referred to as the "State") challenging the State's use of pentobarbital. Rhines also filed his application for a preliminary injunction and stay of execution, his brief in support of his application, an affidavit by his attorney, Dan

Fritz, with documents attached being relied upon by Rhines, and an affidavit by Rhines' expert, Craig Stevens, Ph.D. An amended complaint was filed the next day, October 23, 2019.

Because the execution is scheduled for next week, an expedited hearing was held October 29, 2019. Prior to the hearing, the State submitted a brief opposing Rhines' requests. The State also submitted documents in support of their argument, including a Declaration of Joseph Antognini, M.D.

At the hearing, the parties presented their respective arguments. Rhines also called his expert, Craig Stevens, Ph.D as a witness. Because of the expedited schedule, the State's expert, Joseph Antognini, M.D., was not available to testify, but his affidavit had previously been submitted.

OVERVIEW

In this suit Rhines is not challenging whether he received a fair trial. He is not challenging his conviction for first-degree murder. He is not challenging his sentence of death by lethal injection. He is not challenging whether death by lethal injection violates the Eighth Amendment prohibition against cruel and unusual punishment. He is challenging whether pentobarbital is an ultra-short-acting barbiturate as that phrase was used in SDCL 23A-27A-32.

Barbiturates are a drug group derived from barbituric acid. Barbiturates depress the central nervous system and have long been used as sedatives and hypnotics. Depending on the type of barbiturate and the size of the dosage, the drug can be used to

reduce anxiety, help a person fall asleep, or to render a person unconscious. Depending on the type and the dose, it can also be lethal.

In the two-drug protocol followed by South Dakota in executing a death sentence by lethal injection, a large dose of the barbiturate is administered intravenously. This is intended to cause unconsciousness in less than a minute. After the prisoner is unconscious the prisoner is no longer aware of pain or distress. As the drug continues to affect the body, the respiratory system is suppressed, the brain is deprived of oxygen, and cardiac activity ceases. The barbiturate by itself is sufficient to cause death. To ensure death, however, after the prisoner is unconscious, a paralytic agent is administered intravenously. This further inhibits muscle action, including ceasing cardiac activity.

Rhines agrees this case does not involve a challenge to the paralytic agent the State intends to use, but only a challenge to the use of pentobarbital as the barbiturate the State intends to administer. In support of his challenge, Rhines retained Dr. Craig Stevens. Dr. Stevens has a Ph.D. in Pharmacology and is currently a Professor of Pharmacology at Oklahoma State University. Dr. Stevens submitted an affidavit and testified at the October 29, 2019, hearing. In his opinion, barbiturates are divided into four distinct categories: ultra-short acting, short-acting, intermediate-acting, and long-acting. In his affidavit he states the classifications refer to the time of onset and duration of the drugs' effects. He testified that, the faster the onset (time required for the drug to take effect), the shorter the duration (time it takes for the drug to wear off). During his testimony at the hearing, he added that the classifications also relate to the drugs' lipid solubility.

In Dr. Stevens' opinion, there are two "ultra-short-acting" barbiturates, sodium thiopental and methohexital. Thiopental, the most frequently used ultra-short-acting barbiturate, is used in short-duration surgeries. The onset of anesthesia is usually within 10 to 30 seconds, because thiopental is so lipid soluble that it rapidly enters the brain.

Dr. Stevens also opines that pentobarbital is classified as a short-acting barbiturate, not an ultra-short-acting barbiturate. In support of his opinion, Dr. Stevens references various publications that place pentobarbital in the class of fast-acting barbiturates. He noted that even the package insert for Nembutal Sodium Solution (a brand-name pentobarbital sodium injection) states it is a short-acting barbiturate.

Rhines also relies heavily on a Montana state court decision, *Smith v. State of Montana, Dept. of Corr.*, 2015 WL 5827252 (Mont. Dist. 2015). The trial judge in *Smith*, in interpreting a statute similar to SDCL 23A-27A-32, ruled that pentobarbital is not an ultra-fast-acting barbiturate and enjoined the state from using it in the state's lethal injection protocol. *Id.* It does not appear the *Smith* decision was appealed to the Montana Supreme Court.

The State's expert on this issue is Joseph Antognini, M.D. Dr. Antognini is board certified in anesthesiology and his experience includes being Director of Peri-operative Services at the University of California Davis Health; and a Professor of Anesthesiology and Pain Medicine and Professor of Neurobiology, Physiology, and Behavior at University of California, Davis.

In his Declaration, Dr. Antognini explains that barbiturates can be classified as "ultra-short acting", "ultra-fast acting", "short acting," and "fast acting." These

classifications, however, are not absolute and change depending on the size of the dosage of the drug and whether it is administered orally (a pill) or intravenously.

Importantly, Dr. Antognini explains that the terms "ultra-short acting" and "short-acting" refer to the duration of action of the drug, that is, the length of time the drug has its intended effect (i.e., how long it takes to wear off). Dr. Antognini further explains that "ultra-fast acting" and "fast-acting" refers to the onset of action, in other words the length of time it takes for the effect of the drug to occur.

Exhibit C attached to Dr. Antognini's Declaration shows that a clinical intravenous dosage of thiopental takes effect in 10-40 seconds, while a clinical dosage of pentobarbital takes effect in one minute. In lethal execution dosages, however, while thiopental intravenously still takes effect in 10-40 seconds, pentobarbital takes effect in 20-30 seconds. Accordingly, in lethal execution dosages, pentobarbital's onset may take effect more quickly than thiopental.

In Dr. Antognini's opinion, pentobarbital administered intravenously in the lethal dose the State intends to use in Rhines' execution, will cause Rhines to be unconscious within 20-30 seconds after the initiation of the infusion. This is consistent with the time it would take for Rhines to be unconscious after initiation of an infusion of thiopental (10-40 seconds). Accordingly, pentobarbital is consistent with the classification of an ultra-fast acting/ultra-short acting barbiturate.

Further, in lethal doses, the duration of the drug, whether pentobarbital or thiopental, is meaningless as the inmate will die prior to the time the drug's effects cease. The State argues that it makes no sense and would lead to an absurd result to think that

the legislature was requiring use of a drug, the effects of which would wear off quickly (a drug with a short duration). The drug must be of such duration that its effects extend beyond the time of death. Instead, the State asserts it does make sense that the legislature was referring to a drug that induces a very quick transition from consciousness to unconsciousness. In a lethal intravenous dosage, the transition from consciousness to unconsciousness is virtually the same whether it is thiopental or pentobarbital, and, in fact, may be faster with pentobarbital.

PRELIMINARY INJUNCTION STANDARDS

SDCL 15-6-65 and SDCL Chapter 21-8 confirm that courts have the authority to issue preliminary and permanent injunctions. Whether a preliminary injunction should be issued involves the consideration of four factors, namely: (1) the threat of irreparable harm to the movant; (2) the balance of equities between the parties; (3) the probability that the movant will succeed on the merits; and (4) the public interest. *Dataphase Systems, Inc. v. CL Systems, Inc.*, 640 F.2d 109, 113 (8th Cir. 1981) (en banc); *Hedlund v. River Bluff Estates, LLC*, 2018 S.D. 20, ¶ 15, 908 N.W.2d 766, 771; *Dacy v. Gors*, 471 N.W.2d 576, 579 (S.D. 1991). No single factor is determinative in deciding whether to issue a preliminary injunction. *Dataphase*, 640 F.2d at 113.

Irreparable Harm to the Movant

Death, of course, cannot be undone. Rhines, however, is not asserting in this suit that he should not be put to death by lethal injection. Instead, he asserts that the irreparable harm he will suffer is being deprived of his right to be executed in the manner provided for by South Dakota law, more specifically by the administration of lethal doses

of an ultra-short-acting barbiturate in combination with a paralytic agent. Rhines asserts the only barbiturates that qualify as ultra-short-acting barbiturates are thiopental and methohexital.

The State counters that there is no irreparable harm to Rhines because in lethal doses pentobarbital is an ultra-short-acting barbiturate as that phrase is used in SDCL 23A-27A-32. Further, the effect of pentobarbital in lethal doses is not materially different from the effect of thiopental, and in some circumstances, pentobarbital induces unconsciousness faster than thiopental.

In considering this factor, I find it is neutral, not favoring Rhines or the State.

Balance of Equities Between the Parties

Rhines asserts the harm to the State is a minimal incremental delay and the administrative inconvenience of seeking another execution warrant. Rhines further cites to *Bucklew v. Precythe*,139 S.Ct. 1112, 1146 (2019), for the proposition that "the equities in a death penalty case will almost always favor the prisoner so long as he or she can show a reasonable probability of success on the merits."

The State counters with its own quote from *Bucklew*, that stays of execution "should be the extreme exception, not the norm." *Bucklew*, 139 S.Ct. at 1134. The State has a strong interest in enforcing its criminal judgments. *Hill v. McDonough*, 547 U.S. 573, 584 (2006). In addition, victims of crime (in this case the family of Donnivan Schaeffer) "have an important interest in the timely enforcement of a sentence." *Id.*

As stated in *Nelson v. Campbell*, 541 U.S. 637, 650 (2004), "[g]iven the state's significant interest in enforcing its criminal judgments, there is a strong equitable

presumption against the grant of a stay where a claim could have been brought at such a time as to allow consideration of the merits without requiring entry of a stay."

In *Ledford v. Comm'r, Georgia Dep't of Corr.*, 856 F.3d 1312, 1319-20 (11th Cir. 2017), the court denied a stay even though the inmate's claims were not necessarily barred by the statute of limitations. The court reasoned that the inmate had not been timely in waiting until five days before his execution to raise his claim. *Id.*

In *Jones v. Allen*, 485 F.3d 635 (11th Cir. 2007) an inmate facing imminent execution filed a last-minute challenge to Alabama's execution protocol, which had been adopted four years earlier. The Allen court concluded that the inmate's delay "leaves little doubt that the real purpose behind his claim is to seek a delay of his execution, not merely to effect an alteration of the manner in which it is carried out." *Jones*, 485 F.3d at 640.

In considering the equities in this matter, it is highly doubtful that the real purpose of this suit is Rhines' desire to die by the use of thiopental instead of pentobarbital as the barbiturate used in the two-drug protocol. Instead, the real purpose behind his claim is likely to seek a delay of his execution.

I find that the balance of equities between the parties favors the State.

Public Interest

The public interests in this matter are similar to the balance of equities between the parties, with the additional factor of the public's interest in its citizens and public officials complying with the laws passed by our legislature. The public has a strong interest in making sure the State complies with laws passed by our legislature. This interest is

magnified when the State is carrying out the ultimate criminal penalty—death. Whether this factor favors the State or Rhines, however, depends in large part on this court's findings on the probability of Rhines being successful on the merits of his challenge.

Probability that Movant Will Succeed on the Merits

In this case, the most significant factor in determining whether to grant Rhines' request for an injunction and stay of execution is the probability of Rhines succeeding on the merits of his claim. As stated in Hill, this requires Rhines to show "a significant possibility of success on the merits." *Hill*, 547 U.S. at 584. To determine this, the court must first address the issue of whether Rhines' suit is barred by the doctrine of res judicata.

Res Judicata

The State argues that Rhines' current claims are barred by res judicata. It argues that Rhines could have and should have raised this challenge eight years ago rather than waiting until less than two weeks before his execution is scheduled. The federal courts have held

> "A court considering a stay must ... apply 'a strong equitable presumption against the grant of a stay where a claim could have been brought at such a time as to allow consideration of the merits without requiring entry of a stay.'" *Hill v. McDonough*, 547 U.S. 573, 584, 126 S.Ct. 2096, 165 L.Ed.2d 44 (2006) (quoting *Nelson v. Campbell*, 541 U.S. 637, 650, 124 S.Ct. 2117, 158 L.Ed.2d 924 (2004)).

McGehee v. Hutchinson, 854 F.3d 488, 491 (8th Cir.), *cert. denied*, 137 S. Ct. 1275, 197 (2017).

The 2007 additions to SDCL 23A-27A-32 allow the warden to determine the substances and quantity of substances used for the punishment of death. In 2008, Rhines

amended his pending habeas petition in Pennington County (51 CIV 02-924) to also include a complaint for declaratory and injunctive relief. The declaratory and injunctive relief sought was in response to the statutory language in 23A-27A-32. Rhines' requested relief included: (1) a declaration that an execution carried out by means of the two drug cocktail provided in SDCL 23A-27A-32 in effect at the time of his conviction constitutes cruel and unusual punishment in violation of the South Dakota and United States Constitutions, as well as deprives him of his right to due process of law, and is therefore unconstitutional; and (2) a declaration that SDCL 23A-27A-32, as presently codified, and as applied to Rhines, constitutes an unconstitutional bill of attainder and an unconstitutional ex post facto law and deprives him of his right to due process of the law.

In August 2010, following the changes in 2007 to the statute and the United States Supreme Court decision in *Baze v. Rees,* 553 U.S. 35, the State revised its existing execution policy and protocol ("the protocol"). The protocol used the same three-drug protocol approved in *Baze.* In response to emerging judicial acceptance of pentobarbital as an execution anesthetic, the State again modified the protocol in October of 2011 to also provide for execution via a 1-drug, pentobarbital protocol for all prospective executions. After the adoption of the revised protocol, Rhines was served with notice of the protocol on October 21, 2011. Exhibit 1 attached to the State's brief in this matter is the notice and protocol.

The protocol included a policy on the substances and quantity of substances to be used for executions. The protocol identified the contents of the syringes for 3-Drug, 2-Drug, and 1-Drug executions. With regard to the barbiturates used for executions, the

protocol identified that either sodium thiopental *or* pentobarbital would be used. Importantly, following the charts describing the drugs to be utilized in executions, paragraph 4 on page 3 stated:

> Any person sentenced to death prior to July 1, 2007, may choose to be executed by the 3- or 1-Drug protocol set forth in this document, provided the SDDOC possess the necessary substance or substances for the method chosen at the time scheduled for the inmate's execution, or in the manner provided by South Dakota law at the time of the person's conviction *(2-Drug protocol set forth in this document).*[1]

After notice of the protocol in October of 2011, Petitioner made no further amendments to his petition. A court trial was held over a year later in December of 2012. During this period, discovery ensued and experts were deposed. Experts were deposed largely on the subject of a 3-drug protocol and whether it violates the Eighth Amendment; however, pentobarbital was a subject of frequent questioning. On February 27, 2013, Judge Trimble issued an Order denying Petitioner's claims, which decision included discussions of the use of pentobarbital. Both the circuit court and the South Dakota Supreme Court denied a Certificate of Probable Cause.

"Res judicata precludes relitigation of issues previously heard and resolved; it also bars prosecution of claims that *could have been raised in the earlier proceeding*, even though not actually raised." *Hobart v. Ferebee*, 2009 S.D. 101, ¶ 30, 776 N.W.2d 67, 76 (emphasis added). The South Dakota Supreme Court has also advised that:

> Res judicata consists of two preclusion concepts: issue preclusion and claim preclusion." *Am. Family Ins. Grp. v. Robnik*, 2010 S.D. 69, ¶ 15, 787 N.W.2d

[1] Exhibit 1 attached to State's brief in this matter.

> 768, 774. "Issue preclusion refers to the effect of a judgment in foreclosing relitigation of a matter that has been litigated and decided," and "also is referred to as direct or collateral estoppel." *Id.* (quoting *Migra v. Warren City Sch. Dist. Bd. of Educ.*, 465 U.S. 75, 77 n.1, 104 S.Ct. 892, 894 n.1, 79 L.Ed.2d 56). "Claim preclusion refers to the effect of a judgment in foreclosing litigation of a matter that never has been litigated, because of a determination that it should have been advanced in an earlier suit...." Id (quoting *Migra*, 465 U.S. at 77 n.1, 104 S.Ct. at 894 n.1). "To invoke the doctrine of res judicata, four elements must be established: (1) a final judgment on the merits in an earlier action; (2) the question decided in the former action is the same as the one decided in the present action; (3) the parties are the same; and (4) there was a full and fair opportunity to litigate the issues in the prior proceeding. *People ex rel. L.S.*, 2006 S.D. 76, ¶ 22, 721 N.W.2d 83, 89–90.

Estate of Johnson ex rel Johnson v. Weber, 2017 S.D. 36, ¶ 41, 898 N.W.2d 718, 733, reh'g denied (July 28, 2017).

When examining a res judicata argument, a court is "not restricted to whether the specific question posed by the parties in both actions was the same or whether the legal question posed by the nature of the suit was the same." *Farmer v. S. Dakota Dep't of Revenue & Regulation,* 2010 S.D. 35, ¶ 10, 781 N.W.2d 655, 660. Instead, "[a] cause of action is comprised of the facts which give rise to, or establish, the right a party seeks to enforce." *Merchants State Bank v. Light*, 458 N.W.2d 792, 794 (citing *Bank of Hoven v. Rausch,* 449 N.W.2d 263, 266)). "Essentially, it is the underlying facts which give rise to the cause of action that must determine the propriety or necessity of presenting a specific issue within the prior proceedings." *Lewton v. McCauley*, 460 N.W.2d 728, 731 (S.D. 1990).

This Court considers the cases of *Lewton* and *Farmer* as instructive in understanding res judicata. In both cases, each claim arose out of factually similar

scenarios. In *Farmer,* both claims arose out of the same act: failure to pay taxes. Because both claims came from the same transaction and one already had a final judgment, the Court found that res judicata applied. Similarly, in *Lewton,* both claims arose out of the same scenario: Lewton's bankruptcy. However, the difference in *Lewton* focuses on whether the subsequent claim even existed at the time the first claim was brought. While the first claim concerned the cattle and the contract between the parties, the amount of rent owed is certainly related to both; however, the second claim could not have been brought at that time because the issue of the amount of rent owed derived from the first court's decision. *Lewton* demonstrates that while the two claims may arise out of the same factual scenario, the second claim must have existed at the time if a party is going to assert that the claim should have been brought pursuant to the doctrine of res judicata. *Farmer*, on the other hand, demonstrates two separate claims related to the same action. If the party had a fair opportunity to litigate the second claim during the proceedings of the first claim, res judicata precludes the subsequent action.

Rhines had a full and fair opportunity to challenge the protocol's compliance with the statutes in his 2011 Pennington County action. Rhines was put on notice of the State's intent to use pentobarbital when Rhines was served with a copy of the protocol on October 24, 2011. The protocol contained explicit notice of the State's intention to use pentobarbital in the 2-drug protocol that Rhines ultimately elected. Rhine's then-pending complaint for declaratory and injunctive relief contained general arguments that the protocol denied him due process that he felt he was entitled to under SDCL 23A-27A-32 and opposed the "two chemicals" that would be used. Experts in the case frequently

discussed the use of pentobarbital in the execution. In a deposition taken December 1, 2012, one of Rhine's own experts, Dr. Mark Heath, testified at length about the use of pentobarbital. A copy of Dr. Heath's deposition is attached as Exhibit 8 to the State's brief in this case. Examples of Dr. Heath's discussion of pentobarbital includes testimony on page 21 of the deposition transcript that "pentobarbital is typically put into the short or medium-acting categories." Further on page 22 he discusses the differences between thiopental and pentobarbital. On page 22 he is asked whether he has "reviewed the protocol and have an understanding at least a paper level of how the State of South Dakota intends to use pentobarbital as a lethal injection drug", to which Dr. Heath replies "Yes."

Additionally, during the litigation of Rhine's method of execution claims, the State had an expert opine on whether a 2-drug protocol of pentobarbital and a paralytic agent would provide a painless and humane death for an inmate. Therefore, not only was Rhines put on notice in October of 2011, but he was also put on notice, through the deposition of the experts, of the State's intent to use pentobarbital in carrying out the 2-drug protocol.

Because Rhines was aware of the State's intent to use pentobarbital in its 2-drug protocol, Rhines could have and should have brought a specific challenge to the use of pentobarbital as part of his then-pending complaint for declaratory and injunctive relief eight years ago. While Rhines challenged many other aspects with regard to 23A-27A-32, Rhines failed to present any argument as to pentobarbital when the protocol explicitly listed pentobarbital as one of two drugs that could be administered in the 2-drug protocol.

Because the declaratory action sought in the prior litigation specifically talked about both drugs, the protocol, and the statute, Rhines was bound to bring the claims at that time, not eight years later and just days before his scheduled execution.

The State further asserts that this was a strategic attempt to stay his execution because he also could have asserted the claims in his APA challenge in August of 2018 but did not do so. *See Rhines v. South Dakota Dept. of Corrections*, 2019 S.D. 59, __ N.W.2d __.

At the hearing, Rhines asserted that the claims are not barred by res judicata because the claim was not ripe until the State's non-compliance with the statute. Rhines also argues that the claims asserted are not the same under a res judicata analysis. As to the ripeness, Rhines argues that SDCL 23A-27A-32.1 provides him with a right to elect which method of execution to administer up until 7 days prior to the scheduled week of execution. Thus, the choice to elect which method of execution gives him authority to wait to choose his manner of execution and no issue existed until the State notified him that the barbiturate to be used at his execution would be pentobarbital.

This court finds that argument unpersuasive. As discussed above, Rhines initially filed a habeas petition on unrelated grounds in Pennington County in 2002. Following the amendments to the statutes in 2007, Rhines amended his petition in 2008 seeking declaratory and injunctive relief based on the constitutionality of SDCL 23A-27A-32 before and after the amendments. Many of Rhines' claims related to the changes in the statutes and the lack of specificity of what kind of drugs would be utilized in an execution. The protocol was issued in 2010 and revised in 2011 and provided specific

explanations of the types of drugs the State would utilize, among others. Further, the protocol in paragraph 4 on page 3 made it clear that the 2-drug protocol was exclusively applied to inmates sentenced prior to 2007, such as Rhines. Rhines was put on notice of the adoption and revision of the protocol. The protocol specifically referenced pentobarbital as one of two barbiturates to be used in a 3-, 2-, or 1- drug execution. Rhines had this information and made no amendments to his current declaratory and injunctive requests in his petition. Unlike *Lewton,* Rhines' cause of action existed at the time his Pennington County declaratory judgment action was pending. Rhines had a "full and fair opportunity to litigate" the validity of whether the protocol was in compliance with the language under SDCL 23A-27A-32 at that time.

As to Rhines' ripeness argument, SDCL 21-24-1 permits the declaration of legal rights or relations before an actual injury occurs.[2] When seeking declaratory relief, there are four jurisdictional requirements that must be established:

> (1) There must exist a justiciable controversy; that is to say, a controversy in which a claim of right is asserted against one who has an interest in contesting it; (2) the controversy must be between persons whose interests are adverse; (3) the party seeking declaratory relief must have a legal interest in the controversy, that is to say, a legally protectible interest; and (4) the issue involved in the controversy must be ripe for judicial determination.

Boever v. South Dakota Bd. Of Accountancy, 526 N.W.2d 747, 750 (quoting *Danforth v. City of Yankton*, 25 N.W.2d 50, 53 (S.D. 1946). "Ripeness involves the timing of judicial

[2] SDCL 21-24-1 provides: Courts of record within their respective jurisdictions shall have power to declare rights, status, and other legal relations whether or not further relief is or could be claimed. No action or proceeding shall be open to objection on the ground that a declaratory judgment or decree is prayed for. The declaration may be either affirmative or negative in form and effect; and such declaration shall have the force and effect of a final judgment or decree.

review and the principle that '[j]udicial machinery should be conserved for problems which are real and present or imminent, not squandered on problems which are abstract or hypothetical or remote.'" *Id.* (quoting *Gottschalk v. Hegg,* 228 N.W.2d 640, 643–44 (S.D.1975) (quoting Davis, *Administrative Law Treatise,* § 21.01)).

In *Boever v. South Dakota Bd. of Accountancy,* Boever was a certified public accountant licensed under SDCL ch 36-20A. 526 N.W.2d 747, 748 (S.D. 1995). In order to maintain his licensure, Boever, as well as all CPAs, were subjected to quality reviews every three years pursuant to statute. *Id.* After a statutorily mandated quality review was conducted, the South Dakota Department of Legislative Audit filed a complaint against Boever. *Id.* at 749. In an agreement to terminate disciplinary action against Boever, he agreed to undergo another quality review. *Id.* Shortly after his agreement, Boever filed a complaint in circuit court seeking a declaration at the review and disciplinary statutes were unconstitutional due to vagueness and lack of sufficient standards to constitute a lawful delegation of legislative powers. *Id.* The trial court found that the claims were not ripe because there was "no present controversy." *Id.*

On appeal, the South Dakota Supreme Court affirmed and reversed in part. *Id.* at 751. In the analysis, the Court affirmed the trial court's conclusion that there was no present controversy with regard to the disciplinary statutes. *Id.* at 750. With regard to the quality review statutes, though, the Court reversed and remanded the trial court's decision based on the statutory language that required quality reviews every three years. *Id.* The language there provides for future quality reviews that are "imminent and

inevitable" because a review was bound to happen in the future. *Id.* The court therefore found that the constitutional challenge to the statute was ripe for review. *Id.*

Rhines was lawfully sentenced to death. Like the quality reviews statutes in *Boever,* Rhines execution was "imminent and inevitable." The statutes and protocol undoubtedly applied to Rhines in 2011 as much as it does now in 2019. The issue was ripe in 2011 when the protocol was issued because the protocol explicitly referenced pentobarbital as one of two barbiturates to be used in executions. Further, in his previous litigation in 2011, Rhines specifically referenced both drugs listed in the protocol in his declaratory action. Furthermore, in 2011, when the protocol was issued, the issue now presented was not abstract, hypothetical, or remote at that time.

The State is correct in its assertion that Rhines challenged the exact protocol in 2011 as he is challenging now. The protocol clearly indicated that the State would administer a barbiturate of either sodium thiopental or pentobarbital. Rhines places emphasis on the word *or* and argues that because he did not know which drug the State would use at his execution, the issue was not ripe. However, Rhines argument fails because the issue of the constitutionality of the 3-drug protocol was ripe for judicial review as was demonstrated by the Rhines' declaratory and injunctive action in 2011. Applying Rhines' logic, because the State or Rhines could have elected alternate methods of execution, his original claims in 2011 would also not have been ripe for adjudication. Therefore, the question of whether pentobarbital, as listed in the protocol and discussed in the habeas petition, fits within the statutory definition of an ultra-short acting barbiturate would be ripe as well.

The Eighth Circuit's decision in *McGehee v. Hutchinson*, in another death penalty case challenging the drug cocktails, also supports this court's decision. "Whether or not the claim technically is barred by doctrine of res judicata or collateral estoppel, the prisoners' use of "piecemeal litigation" and dilatory tactics is sufficient reason by itself to deny a stay." *McGehee v. Hutchinson*, 854 F.3d 488, 492-92 (8th Cir.), *cert. denied*, 137 S. Ct. 1275, 197 L.Ed. 2d 746 (2017) (quoting *Hill v. McDonough*, 547 U.S. at 584-85, 126 S.Ct. 2096). "Both the State and the victims of crime have an important interest in the timely enforcement of a sentence." *Hill v. McDonough*, 547 U.S. 573, 584, 126 S. Ct. 2096, 2104, 165 L. Ed. 2d 44 (2006) (quoting *Calderon v. Thompson,* 523 U.S. 538, 556, 118 S.Ct. 1489, 140 L.Ed.2d 728 (1998)).

The Court finds there is a strong probability that Rhines' claims are barred by res judicata, and further finds there is not a significant possibility that Rhines will be successful on the merits of the res judicata issue. Because of the court's finding on the res judicata issue, it does not need to, and does not, make a finding regarding whether pentobarbital is an ultra-short acting barbiturate as that phrase is used in SDCL 23A-27A-32.

ORDER

Based upon the foregoing, Rhines' request for a temporary restraining order and preliminary injunction is denied. Rhines' request for a stay of execution is also denied.

Dated this 31st day of October, 2019.

BY THE COURT:

Jon C. Sogn
Circuit Court Judge

ATTEST:
Angelia M. Gries, Clerk of Court

By: _____
Deputy Clerk

STATE OF SOUTH DAKOTA	) :SS	IN CIRCUIT COURT
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

CHARLES RUSSELL RHINES, Plaintiff, v. SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, SECRETARY, SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY, and JASON R. RAVNSBORG IN HIS CAPACITY AS THE ATTORNEY GENERAL FOR THE STATE OF SOUTH DAKOTA, Defendants.	CIV. 19-_____ **THIS IS A CAPITAL CASE EXECUTION SET FOR BETWEEN NOVEMBER 3, 2019 AND NOVEMBER 9, 2019**

COMPLAINT

COMES NOW PLAINTIFF, and for his Complaint against Defendants, states and alleges as follows:

INTRODUCTION

1. This is a Complaint seeking injunctive and declaratory relief directing Defendants South Dakota Department of Corrections ("DOC"), Mike Leidholt, Secretary of the DOC, Darin Young, in his capacity as warden of the South Dakota State Penitentiary, and Jason R. Ravnsborg, in his capacity as the Attorney General for the State of South Dakota (collectively, "Defendants") to execute Plaintiff Charles Russell Rhines ("Rhines") in accordance with South Dakota Codified Law, to wit, "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict

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is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch. 181, codified at SDCL 23A-27A-32. (1984).

2. Rhines is a prisoner sentenced to death by the State of South Dakota on January 29, 1993.

3. Rhines's execution week is November 3, 2019 through November 9, 2019.

4. SDCL § 23A-27A-32.1 provides in pertinent part that "Any person convicted of a capital offense or sentenced to death prior to July 1, 2007 may choose to be executed in the manner provided in § 23A-27A-32 or in the manner provided by South Dakota law at the time of the person's conviction or sentence. The person shall choose by indicating in writing to the warden not less than seven days prior to the scheduled week of execution the manner of execution chosen." SDCL § 23A-27A-32.1.

5. At the time that Rhines was convicted and sentenced, South Dakota law provided, in pertinent part, that: "The punishment of death shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch. 181, codified at SDCL § 23A-27A-32 (1984).

6. In enacting SDCL § 23A-27A-32.1, the State of South Dakota created a statutory right that entitles Rhines to be executed in the manner provided by South Dakota law at the time of Rhines's conviction or sentence if he chooses that manner.

7. The State, in enacting SDCL § 23A-27A-32.1, also created life and liberty interests entitling Rhines to the same. Rhines's life and liberty interest is protected by the Due Process Clause

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of the Fourteenth Amendment of the United States Constitution and the Due Process Clause of Article Six, Section 2 of the South Dakota Constitution.

8. In a Kite-Request Slip dated October 1, 2019, addressed to Defendant Young, Rhines chose to be executed in the manner that was in effect at the time that he was sentenced to death.

9. In an amended Kite-Request Slip dated October 4, 2019, addressed to Defendant Young, Rhines chose to be executed in the manner that was in effect at the time that he was sentenced to death, to wit, "[t]he Two Drug Protocol of a Lethal Dose of An Ultra-Short Acting Barbiturate and a Chemical Paralytic."

10. On October 15, 2019, attorneys for Rhines, emailed and mailed a letter to Defendants Young and Ravnsborg, and Paul Swedlund, Assistant Attorney General in the Office of the Defendant Attorney General, requesting, among other things, confirmation that Rhines's request to be executed by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent would be honored.

11. In a letter dated October 17, 2019, Assistant Attorney General Swedlund advised counsel that he had received "Mr. Rhines' request for execution pursuant to the combination of drugs provided by statute at the time of his execution." Mr. Swedlund noted that "DOC will follow the law." Mr. Swedlund further informed counsel that "[t]he ultra-short-acting barbiturate the state intends to use is pentobarbital."

12. Upon information and belief, pentobarbital is not an ultra-short-acting barbiturate.

13. Numerous courts have held that pentobarbital is not an ultra-short-acting barbiturate. *See, e.g.*, *Smith v. Montana*, No. BDV-2008-303, 2015 WL 5827252 (Mont. Dist. Ct. Lewis and Clark County Oct. 6, 2015) (unpublished) (attached hereto as Exhibit A) ("This Court rules that pentobarbital is not an ultra-fast-acting barbiturate. The State of Montana will either need to select a

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barbiturate that is ultra-fast acting to accomplish the execution of Plaintiffs or it will need to modify its statute.")

14. Medical journals provide that pentobarbital is not an ultra-short-acting barbiturate.

15. Defendants' decision to used pentobarbital, contrary to South Dakota law, deprives Rhines of his statutory right to be executed in the manner of his choice. It also deprives Rhines of his life and liberty interests in being executed in the manner of his choice without due process of law guaranteed under the Due Process Clause of the Fourteenth Amendment of the United States Constitution and the Due Process Clause of Article Six, Section 2 of the South Dakota Constitution.

16. Rhines's execution week is a mere two weeks away. Thus, Rhines brings this action for injunctive and declaratory relief to enforce his right under South Dakota law to be executed by the manner he chose, intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent, and not by pentobarbital which is neither an ultra-short-acting barbiturate nor a chemical paralytic agent.

PARTIES

17. Plaintiff Rhines is a United States citizen and a resident of the State of South Dakota. He is currently a condemned inmate in the custody of Defendants and under the supervision of the DOC in Sioux Falls, South Dakota.

18. Defendant South Dakota Department of Corrections ("DOC") is an agency of the State of South Dakota. The DOC is responsible for all prisons in the State of South Dakota, for the custody and treatment of death-sentenced inmates, and for the execution of such inmates.

19. Defendant Mike Leidholt is the Secretary of the DOC and is sued in his official capacity.

20. Defendant Darin Young is the Warden of the South Dakota State Penitentiary and is sued in his official capacity.

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21. Defendant Jason R. Ravnsborg is the Attorney General for the State of South Dakota and is sued in his official capacity.

JURISDICTION AND VENUE

22. This Court has jurisdiction to adjudicate this action under the South Dakota Uniform Declaratory Judgments Act, SDCL § 21-24-1 et seq.

23. Venue in this Court is proper under SDCL § 15-5-2(2), which provides that an action against a public officer shall be brought in the county where the cause, or some part thereof, arose. The injury to Plaintiff because of Defendants' illegal actions has occurred and will occur in the County of Minnehaha and, as such, venue is proper in this Court.

FACTS

24. Rhines was sentenced to death on January 29, 1993.

25. On June 25, 2019, Judge Robert Mandel granted a warrant of execution, which sets forth that Rhines shall be executed between November 3 and November 9, 2019.

26. SDCL § 23A-27A-32.1 provides that:

> Any person convicted of a capital offense or sentenced to death prior to July 1, 2007 may choose to be executed in the manner provided in § 23A-27A-32 ***or in the manner provided by South Dakota law at the time of the person's conviction or sentence***. The person shall choose by indicating in writing to the warden not less than seven days prior to the scheduled week of execution the manner of execution chosen. If the person fails or refuses to choose in the time provided under this section, then the person shall be executed as provided in § 23A-27A-32.

SDCL § 23A-27A-32.1 (emphasis added).

27. At the time that Rhines was convicted and sentenced, in 1993, South Dakota law provided, in pertinent part, that, "The punishment of death shall be inflicted by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch 181.

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28. In 2007, the South Dakota Legislature amended the law as follows:

SOUTH DAKOTA 2007 SESSION LAWS
2007 REGULAR SESSION OF THE 82ND LEGISLATURE

Additions are indicated by Text; deletions by
~~Text~~ . Changes in tables are made but not highlighted.

Ch. 151 (HB 1175)
West's No. 101
CAPITAL PUNISHMENT—LETHAL INJECTION—SUBSTANCES

FOR AN ACT ENTITLED, An Act to provide for the substances used in the execution of a sentence of death and to allow the choice of the substances used in an execution under certain circumstances.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That § 23A–27A–32 be amended to read as follows:

<< SD ST § 23A–27A–32 >>

23A–27A–32. The punishment of death shall be inflicted within the walls of some building at the state penitentiary ~~or within the yard or enclosure adjoining thereto~~ . The punishment of death shall be inflicted by the ~~intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice~~ intravenous injection of a substance or substances in a lethal quantity. The warden, subject to the approval of the secretary of corrections, shall determine the substances and the quantity of substances used for the punishment of death. An execution carried out by ~~lethal~~ intravenous injection shall be performed by a person ~~selected by the warden and~~ trained to administer the injection who is selected by the warden and approved by the secretary of corrections. The person administering the intravenous injection need not be a physician, registered nurse, ~~or~~ licensed practical nurse, or other medical professional licensed or registered under the laws of this or any other state. Any infliction of the punishment of death by ~~administration of the required lethal~~ intravenous injection of a substance or substances in the manner required by this section may not be construed to be the practice of medicine ~~and any~~ . Any pharmacist or pharmaceutical supplier is authorized to dispense the ~~drugs~~ substance or substances used to inflict the punishment of death to the warden without prescription, for carrying out the provisions of this section, notwithstanding any other provision of law.

Section 2. That chapter 23–A–27A be amended by adding thereto a NEW SECTION to read as follows: Any person convicted of a capital offense or sentenced to death prior to the effective date of this Act may choose to be executed in the manner provided in this Act or in the manner provided by South Dakota law at the time of the person's conviction or sentence. The person shall choose by indicating in writing to the warden not less than seven days prior to the scheduled week of execution the manner of execution chosen. If the person fails or refuses to choose in the time provided under this section, then the person shall be executed as provided in section 1 of this Act.

Approved February 23, 2007.

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29. In 2008, the South Dakota Legislature further amended the law as follows:

SOUTH DAKOTA 2008 SESSION LAWS

2008 REGULAR SESSION OF THE 83RD LEGISLATURE

Additions are indicated by Text; deletions by

~~Text~~ . Changes in tables are made but not highlighted.

Ch. 117 (SB 53)

West's No. 244
CAPITAL PUNISHMENT—JUDGES—WARRANTS

FOR AN ACT ENTITLED, An Act to revise certain provisions related to capital punishment.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

* * * * * * * * * * * * *

<< SD ST § 23A–27A–32 >>

23A–27A–32. The punishment of death shall be inflicted within the walls of some building at the state penitentiary. The punishment of death shall be inflicted by the intravenous injection of a substance or substances in a lethal quantity. The warden, subject to the approval of the secretary of corrections, shall determine the substances and the quantity of substances used for the punishment of death. An execution carried out by intravenous injection shall be performed by ~~a person~~ persons trained to administer the injection who ~~is~~ are selected by the warden and approved by the secretary of corrections. The ~~person~~ persons administering the intravenous injection need not be ~~a physician~~ physicians, registered ~~nurse~~ nurses, licensed practical ~~nurse~~ nurses, or other medical ~~professional~~ professionals licensed or registered under the laws of this or any other state. Any infliction of the punishment of death by intravenous injection of a substance or substances in the manner required by this section may not be construed to be the practice of medicine. Any pharmacist or pharmaceutical supplier is authorized to dispense to the warden the substance or substances used to inflict the punishment of death ~~to the warden~~ without prescription, for carrying out the provisions of this section, notwithstanding any other provision of law.

30. In a Kite-Request Slip dated October 1, 2019, addressed to Defendant Young, Rhines pursuant to SDCL § 23A-27A-32.1, elected the method of execution that was in effect at the time that he was sentenced to death. (A true and correct copy of the October 1, 2019 Kite-Request Slip is attached hereto as Exhibit B.)

31. In an amended Kite-Request Slip dated October 4, 2019, addressed to Defendant Young, Rhines elected the method of execution that was in effect at the time that he was sentenced to death, to wit, "[t]he Two Drug Protocol of a Lethal Dose of An Ultra-Short Acting Barbiturate and

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a Chemical Paralytic." (A true and correct copy of the October 4, 2019 Kite-Request Slip is attached hereto as Exhibit C.)

32. As of October 15, 2019, Defendant Young had not responded to Rhines's Kite-Request Slips. On October 15, 2019, attorneys for Rhines, emailed and mailed a letter to Defendant Young, Defendant Ravnsborg, and Paul Swedlund, Assistant Attorney General in the office of the Attorney General, requesting, among other things, confirmation that Rhines's request to be executed by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent would be honored. (A true and correct copy of the October 15, 2019 letter is attached hereto as Exhibit D.)

33. Rhines's attorneys also requested that the Defendants identify which ultra-short-acting barbiturates will be used to execute Mr. Rhines. (*Id*.)

34. On October 17, 2019, Mr. Swedlund, from the office of Defendant Young, emailed attorneys for Rhines a letter stating, "I am in receipt of your letter regarding Mr. Rhines' request for execution pursuant to the combination of drugs provided by statute at the time of his execution. The DOC will follow the law. The ultra-short-acting barbiturate the state intends to use is pentobarbital." (A true and correct copy of the October 17, 2019 letter is attached hereto as Exhibit E.)

35. Upon information and belief, ultra-short-acting barbiturates include sodium methohexital and sodium thiopental.

36. Upon information and belief, pentobarbital is not an ultra-short-acting barbiturate. Nor is it a chemical paralytic agent.

37. Defendants intend to execute Mr. Rhines, in contravention of his statutory right to elect the method of his execution, with pentobarbital, a drug that is not an ultra-short-acting barbiturate. Pentobarbital is not a chemical paralytic agent either.

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First Cause of Action—Violation of the Right to Choose the Manner of Execution Provided by Law at the Time of Sentence (Against All Defendants)

38. Rhines incorporates by reference each and every allegation contained in the foregoing paragraphs as if specifically alleged herein.

39. In enacting SDCL § 23A-27A-32.1, the State of South Dakota created and codified a state statutory right that entitles Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence. Defendants have a corresponding duty to ensure Rhines can exercise this right.

40. The manner of execution provided by South Dakota law at the time of Rhines's conviction and sentence was, in relevant part, "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch. 181, codified at SDCL § 23A-27A-32 (1984).

41. SL 1984, ch 181 created a right to an execution "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch. 181, codified at SDCL § 23A-27A-32 (1984).

42. Rhines has a right to execution "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." *Id.*

43. Rhines's right to be executed in the manner set forth in SL 1984, ch 181 is codified and protected by SDCL § 23A-27A-32.

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44. Rhines has exercised his right to choose the manner set forth in SL 1984, ch 181. Rhines has done so in accordance with the provisions of SDCL § 23A-27A-32.1.

45. Defendants cannot deprive Rhines of his right to be executed in the manner of his choice. Defendants have a duty to ensure Rhines can exercise his right.

46. Defendants assert pentobarbital is an ultra-short-acting barbiturate. (Exh. E.)

47. Upon information and belief, pentobarbital is neither an ultra-short-acting barbiturate nor a chemical paralytic agent.

48. Upon information and belief, ultra-short-acting barbiturates include sodium methohexital and sodium thiopental.

49. By refusing to guarantee that Rhines will be executed in the manner set forth in SL 1984, ch 181, Defendants are depriving Rhines of his state statutory right created and protected by SDCL § 23A-27A-32.1 and SL 1984, ch. 181, codified at SDCL § 23A-27A-32 (1984).

Second Cause of Action– Deprivation of Due Process (Against All Defendants)

50. Rhines incorporates by reference each and every allegation contained in the foregoing paragraphs as if specifically alleged herein.

51. In enacting SDCL § 23A-27A-32.1, the State of South Dakota created life and liberty interests that entitle Rhines to be executed in the manner provided by South Dakota law at the time of the Rhines's conviction or sentence.

52. The manner of execution provided by South Dakota law at the time of Rhines's conviction and sentence was, in relevant part, "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch 181.

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53. SL 1984, ch 181 creates protected life and liberty interests in execution "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch 181.

54. Rhines has life and liberty interests in execution "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch 181.

55. Rhines's life and liberty interests in being executed in the manner set forth in SL 1984, ch 181 are protected by the Due Process Clause of the Fourteenth Amendment of the United States Constitution.

56. Rhines's life and liberty interests in being executed in the matter set forth in SL 1984, ch 181 are protected by the Due Process Clause of Article Six, Section 2 of the South Dakota Constitution.

57. By stating their intention to execute Rhines using pentobarbital, which is neither an ultra-short-acting barbiturate nor a chemical paralytic agent, Defendants are deliberately and intentionally depriving Rhines of his life and liberty interests to be executed in the manner of his choice without due process of law.

Third Cause of Action – Injunctive Relief (Against All Defendants)

58. Rhines incorporates by reference each and every allegation contained in the foregoing paragraphs as if specifically alleged herein.

59. Defendants' decision to use pentobarbital to execute Rhines deprives Rhines of his statutory right to be executed using an ultra-short-acting barbiturate. It also deliberately and

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intentionally deprives Rhines of his life and liberty interests in being executed using an ultra-short-acting barbiturate without due process of law guaranteed under the United States and South Dakota Constitutions.

60. Rhines has a substantial likelihood of success on the merits of his claims.

61. Rhines will suffer severe and irreparable injury if Defendants are not enjoined from executing Rhines with pentobarbital, in violation of his rights.

62. The interests of justice will be served by the Court ordering that: (a) Defendants are prohibited from executing Rhines with Pentobarbital, and; (b) Defendants are required to execute Rhines "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate", to wit, sodium methohexital or sodium thiopental.

Fourth Cause of Action – Declaratory Judgment (Against All Defendants)

63. Rhines incorporates by reference each and every allegation contained in the foregoing paragraphs as if specifically alleged herein.

64. The Uniform Declaratory Judgment Act, SDCL§ 21-24-1, provides that the "Courts of record within their respective jurisdictions shall have power to declare rights, status, and other legal relations whether or not further relief is or could be claimed. No action or proceeding shall be open to objection on the ground that a declaratory judgment or decree is prayed for. The declaration may be either affirmative or negative in form and effect; and such declaration shall have the force and effect of a final judgment or decree."

65. A valid case or controversy exists between the parties because Defendants intend to execute Rhines in violation of Rhines's statutory and constitutional rights.

66. Rhines seeks a declaration that pentobarbital is not an ultra-short-acting barbiturate.

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67. Rhines seeks a declaration that Defendants are enjoined from executing Rhines with pentobarbital.

68. Rhines seeks a declaration that: (a) Defendants are prohibited from executing Rhines with Pentobarbital, and; (b) Defendants are required to execute Rhines "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate", to wit, sodium methohexital or sodium thiopental.

69. Rhines has suffered and will suffer an injury in fact based upon Defendants' deprivation of his statutory and due process rights.

70. There is a causal connection between Rhines's injury and Defendants' conduct.

71. Rhines's injury will be redressed by a judgment declaring that: (a) pentobarbital is neither an ultra-short-acting barbiturate nor a chemical paralytic agent; (b) Defendants are enjoined from executing Rhines with pentobarbital, and (c) Defendants are required to execute Rhines only "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate", to wit, sodium methohexital or sodium thiopental.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment against Defendants as follows:

A. A judgment declaring that: (1) pentobarbital is not an ultra-short-acting barbiturate; (2) Defendants are enjoined from executing Rhines with pentobarbital, and (3) Defendants are required to execute Rhines only "by the intravenous administration of a lethal quantity of an ultra-short-acting barbiturate", to wit, sodium methohexital or sodium thiopental.

B. A preliminary and permanent injunction ordering that: (1) Rhines's execution is stayed pending adjudication of this action; (2) pentobarbital is not an ultra-short-acting barbiturate; (3) Defendants are enjoined from executing Rhines with pentobarbital, and (4) Defendants are required to execute Rhines only "by the intravenous administration of a

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lethal quantity of an ultra-short-acting barbiturate", to wit, sodium methohexital or sodium thiopental.

C. For other and further relief as the court deems proper.

Dated this 22nd day of October, 2019.

BALLARD SPAHR LLP

By: /s/ Daniel R. Fritz

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2015 WL 5827252 (Mont.Dist.) (Trial Order)
District Court of Montana.
First Judicial District Court
Lewis And Clark County

Ronald Allen SMITH and William Gollehon, Plaintiffs,
v.
STATE OF MONTANA, DEPARTMENT OF CORRECTIONS; Director Mike Batista; Warden Leroy Kirkegard; and John Does 1-20, Defendants.

No. BDV-2008-303.
October 6, 2015.

Findings of Fact, Conclusions of Law and Order

Ronald F. Waterman.

Jim Taylor.

Gregory A. Jackson.

Michael Donahoe.

Timothy C. Fox/ C. Mark Fowler/Pamela P. Collins/Jonathan M. Krauss, Robert Stutz.

Jeffrey M. Sherlock, Judge.

INTRODUCTION

*1 Before proceeding, it important to clarify the nature of this case. This Court has not been asked and will not make a determination as to whether lethal injection of the Plaintiffs constitutes cruel and unusual punishment. This case is not about the constitutionality or appropriateness of the death penalty in Montana. This case is not about whether the use of pentobarbital in a lethal injection setting is cruel and unusual or if pentobarbital in the doses contemplated by the State of Montana would produce a painless death. Further, this case is not about the availability of pentobarbital or any other drug. This case is only about whether the drug selected by the Department of Corrections to effectuate the Plaintiffs' lethal injections, pentobarbital, meets the legislatively required classification of being an "ultra-fast acting barbiturate."

This Court rules that pentobarbital is not an ultra-fast-acting barbiturate. The State of Montana will either need to select a barbiturate that is ultra-fast acting to accomplish the execution of Plaintiffs or it will need to modify its statute as will be detailed below.

From the testimony and evidence presented, the Court enters the , following:

FINDINGS OF FACT

Trial in this matter was held on September 2 and 3, 2015. Representing Plaintiffs were Ronald F. Waterman, James Park Taylor, and Gregory A. Jackson. Representing the State of Montana were C. Mark Fowler, Pamela P. Collins, Jonathan M. Krause, and Robert Stutz. The Court received numerous exhibits and heard from two witnesses, Dr. Mark Heath and Dr. R. Lee Evans.

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Jurisdiction and venue are proper in this Court.

Plaintiff Ronald Allen Smith, an inmate at Montana State Prison, has been sentenced to death for the killing of two young men in 1982.

Plaintiff William J. Gollehon, an inmate at Montana State Prison, has been sentenced to death for the killing of another inmate at Montana State Prison in 1990.

The Montana Supreme Court has upheld the death sentences of both Plaintiffs. *State v. Smith*, 280 Mont. 158, 931 P.2d 1272 (1996); *State v. Gollehon*, 262 Mont. 1, 864 P.2d 249 (1993).

Session law 1983 Montana Laws chapter 411 enacted lethal injection as an option for the execution of prisoners sentenced to death. That provision introduced the phrase "ultra-fast-acting barbiturate" into Montana Code Annotated § 46-19-103.

As of March 19, 1997, lethal injection became the sole method of execution of a sentence of death.

Montana Code Annotated § 46-19-103(3) provides: "[t]he punishment of death must be inflicted by administration of a continuous, intravenous injection of a lethal quantity of an ultra-fast-acting barbiturate in combination with a chemical paralytic agent until a coroner or deputy coroner pronounces that the defendant is dead."

The current Execution Technical Manual (ETM) was adopted on January 16, 2013. (*See* PL's Ex. 1.) The two-drug protocol is referenced on pages 41, and 50 through 53 of the current ETM. There it is indicated that sodium pentothal and pancuronium bromide will be used in the execution. At page 51, it is indicated that these drugs may be substituted by another drug based on availability. It is specifically provided that pentobarbital with a dosage of 5 gms may be substituted for sodium pentothal. Further, rocuronium bromide with a dosage of 1,000 mgs may be substituted for pancuronium bromide.

***2** The State of Montana is the only state that specifies that the death penalty be accomplished by an "ultra-fast-acting barbiturate." The other states employing the death penalty either specify a particular drug to be used or merely state that execution is to take place by means of lethal injection.

The only issues remaining in this case are what the Montana legislature meant by using the words "ultra-fast-acting barbiturate" in Montana Code Annotated § 46-19-103, and whether pentobarbital is an ultra-fast-acting barbiturate within the meaning of Montana Code Annotated § 46-19-103.

Pentobarbital and thiopental are included in the class of drugs known as barbiturates.

At trial, the first witness was Dr. Mark Heath. His curriculum vitae was received as Plaintiffs Exhibit 8. Dr. Heath is a practicing anesthesiologist in New York at the Columbia Medical Center and also teaches medicine at the Columbia School of Medicine. Dr. Heath is a Board Certified Anesthesiologist and has written extensively on lethal injection. He has testified before various courts and legislatures, and has written articles and book chapters about lethal injection. Dr. Heath has also extensively studied various types of lethal injection, by reviewing witnesses descriptions, execution logs, publications, and electroencephalogram results of people who have been executed by means of lethal injection. All of Dr. Heath's opinions, which will be cited below, were given with a reasonable degree of medical certainty. The bottom line for Dr. Heath is that pentobarbital — the drug selected by the Montana Department of Corrections — is not an ultra-fast-acting barbiturate.

Barbiturates were first created in the 1930s and, as a class, share a certain common core ring of molecules. In general, barbiturates are weak acids that are absorbed and rapidly distributed to all tissues of the human body. Barbiturates are known by their

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lipid solubility. Barbiturates possessing more lipid solubility distribute more rapidly to the human brain. The basic core ring of barbiturate molecules has been modified over the years, and those modifications affect how certain barbiturates operate.

Experts speak of "vein-to-brain time," which is the amount of time it takes a barbiturate injected into the blood stream to transit to the human brain. In addition, there is a "blood-brain barrier." This is a grouping of cells and capillaries around the human brain that prevent toxins from entering the brain. Certain modifications to the basic barbiturate structure have allowed a rapid transfer through the blood-brain barrier. According to Dr. Heath, it is often important to have a very quick transition from consciousness to unconsciousness, quickly penetrating the blood-brain barrier, which allows physicians to lake control of a patient's breathing to prevent negative consequences from occurring as a patient enters unconsciousness. According to Dr. Heath, this is the purpose of the development of ultra-fast-acting barbiturates.

Barbiturates are traditionally classified as long-acting (phenobarbital), medium-acting (such as pentobarbital), short-acting (secobarbital), and ultra-short-acting (thiopental). (*See* Test. Dr. Mark Heath; PL's Ex. 4, Margaret Wood, Alistair J.J. Wood, DRUGS AND ANESTHESIA PHARMACOLOGY FOR ANESTHESIOLOGISTS (2d. ed.,Williams & Wilkins); *see also* PL's Ex. 5, Ronald D. Miller, MILLER'S ANESTHESIA, 6th ed. (2005). According to Dr. Heath and MILLER'S ANESTHESIA, the ultra-short-acting drugs are thiopental, methohexital, and thiamylal. By using terms such as short-acting or ultra-short-acting, the classification system refers to the duration of action or how long the barbiturate exercises its control over the human body.

***3** As noted by Dr. Heath, there is another classification of barbiturates which refers to the onset of action of the barbiturate or how soon the maximum effect is felt by the body. According to Dr. Heath, there is a correspondence between the two systems, and the terms ultra-fast and ultra-short refer to the same type of barbiturates, as do the terms fast and short, and as do the terms slow and long. Putting this in a tabular form, we find the following:

1. Ultrafast acting	Ultrashort acting	thiopental, thiamylal, methohexital
2.* Fast acting	Short acting	secobarbital, pentobarbital
3.* Intermediate acting	Intermediate acting	pentobarbital*
4. Slow acting	Long acting	phenobarbital

(*Some systems combine #2 and #3 into one group of intermediate acting drugs) (PL's Rebuttal Expert Disclosure, at 4 (June 25, 2013).) According to Dr. Heath, pentobarbital is either classified "fast," "short," or "intermediate."

Pentobarbital is not used as an anesthetic, according to Dr. Heath, because its effects last too long. Rather, pentobarbital is commonly used in pill form as a treatment for epilepsy and is also used to induce comas in already unconscious patients. Pentobarbital in the doses suggested in Montana's ETM would undoubtedly cause the death of the inmate.

Dr. Heath has used, in a clinical setting, both pentobarbital and thiopental. Dr. Heath has never heard, prior to this case, any reference to pentobarbital being classified as being ultra-fast acting. According to Dr. Heath, the operation of thiopental and pentobarbital is noticeably different. Dr. Heath testified that an administration of thiopental causes a "lights out" effect, where a patient is unable to complete the thought that was in their mind upon the administration of the drug. A patient receiving thiopental would take one or two breaths before the drug exerted its control over the patient. Heath also opined that an individual given pentobarbital would breathe longer, would have various body movements, and would slur words before the pentobarbital took effect. Heath testified that a patient given pentobarbital would physically be able to appreciate the accrual of sleepiness or unconsciousness, while a patient given thiopental would not.

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Of significant import to the Court is the manufacturer's insert provided for pentobarbital. (*See* PL's Ex. 7, manufacturer's insert for Nembutal Sodium Solution (the manufacturer's name for pentobarbital).) At page one, the insert states "NEMBUTAL Sodium is a short-acting barbiturate." This comports with the classification stated by Dr. Heath.

Plaintiffs Exhibit 11 contains a compilation of a search engine results completed by Dr. Heath. His research shows that there were 28,600 results produced for a description of thiopental as an ultra-short-acting barbiturate. An additional 42 results were returned for the search phrase of thiopental being an ultra-fast-acting barbiturate. On the other hand, the search engine reported one finding for pentobarbital being an ultra-short-acting barbiturate, and a single finding of pentobarbital being an ultra-fast-acting barbiturate. (PL's Ex. 11, at 3.)

The State produced the testimony of Dr. R. Lee Evans, a doctor of pharmacy and Dean of Pharmacy at Auburn University. In Dr. Evans' original declaration filed in March 2015 and received into evidence as Plaintiffs Exhibit 9, he is "not aware of the origin of the term "ultra-fast acting." (PL's Ex. 9, at 6, ¶ 14.) According to Dr. Evans, pentobarbital could be considered short acting, and thiopental, ultra-short acting. (Id.) Dr. Evans opined that there is no meaningful difference between pentobarbital and thiopental in the time it takes to render a person comatose. (Id., at 7, ¶ 15.) However, Dr. Evans noted that onset of action for pentobarbital is under a minute, while for thiopental, the onset of action could be ten to forty seconds. (Id.)

***4** Until the trial of this action. Dr. Evans had not testified that pentobarbital was an ultra-fast-acting barbiturate. lie did so testify at trial. However, the Court struck that conclusion because it did not comport with his prior discovery responses or declarations filed with the Court. (*See* PL's Exs. 9, 10.) At the trial of this matter, Dr. Evans indicated that the onset of pentobarbital was under one minute. However, on December 10, 2012, Dr. Evans indicated "[thiopental is an onset of about a half to one minute, duration of a little less than 30 minutes. Pentobarbital is onset three to four minutes with a duration that is somewhat longer. That's the primary difference." (PL's Ex. 14, *Pardo v. Palmer*, Case No. 3:12-cv-1328-J-32JBT (M.D. Fl. Dec. 10, 2012), Test. Roswell Lee Evans, Jr., at 68).) This testimony stands in stark contrast to what Dr. Evans stated at the trial this matter.

Dr. Evans pointed out that there is no question that pentobarbital is fast acting. For example, Plaintiffs Exhibit 7 — the package insert for pentobarbital — indicates that "the onset of action ranges from almost immediate...." (PL's Ex. 7, at 2.) See also Defendant's Exhibit L, a TOXNET reference which indicates that the onset of thiopental and pentobarbital is "almost immediate. (Def.'s Ex. L, at 16.) TOXNET is a collection of databases operated by the National Library of Medicine. See also Defendant's Exhibit N, a *Drugs.com* reference which indicates that the onset of pentobarbital is immediate. (Def.'s Ex. N, at 1.) Thus, there is no question that pentobarbital is fast acting. The question remains as to whether it is ultra-fast acting.

Dr. Evans did cite to references that indicate that if the onset of action of a drug is less than a minute, it can be considered ultra-fast acting. (*See.* e.g., PL's Ex. Q, TOXNET reference, at 12; PL's Ex. R, Micromedic reference, at 4 ("ultra-fast acting has an onset of one minute or less.).) The Court notes that at page 1 of Exhibit R, pentobarbital is listed as being "short acting," not ultra-short acting.

These references to pentobarbital being ultra-fast acting are consistent with Dr. Heath's finding *some* sources refer to pentobarbital as being ultra-fast acting. However, that must be compared with the greater weight of authority that indicates that pentobarbital is not in the class of drugs considered to be ultra-fast acting.

Dr. Evans did indicate that, in his opinion, pentobarbital and thiopental are almost identical. Both, in his current opinion, reach maximum effect in less than one minute's time. However, Dr. Evans did acknowledge that thiopental is a little quicker to get to the brain because pentobarbital is not as lipid soluble.

In making its decision, this Court has had to weigh the evidence presented by Dr. Evans versus Dr. Heath. Supporting Dr. Heath's testimony are standard pharmacology for anaesthesiologists text books (PL's Exs. 4, 5) and Dr. Heath's own consistent testimony. Also supporting Dr. Heath's position is the significant research that classifies thiopental as being ultra-short acting

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(ultra-fast acting) and not so classifying pentobarbital, except for a few scattered references. (*See* PL's Ex. 11.) Also of utmost import is the manufacturer's insert for pentobarbital (PL's Ex. 7), which classifies pentobarbital as a short-acting barbiturate. Also crucial in this weighing the Court has undertaken is the fact that in the *Pardo v. Palmer* case, in testimony given not three years ago, Dr. Evans testified that pentobarbital's onset of action is three to four minutes as opposed to the less than one minute referred to in his testimony in this case. This is not to in any way insinuate that Dr. Evans is not a credible witness. However, it is a factor when weighing the evidence which shows by a relatively overwhelming nature that, while pentobarbital may operate in a fast nature, it is not ultra-fast as is required to comply with Montana's execution protocol. Thus, through this weighing process, this Court concludes that pentobarbital is not an ultra-fast-acting barbiturate.

***5** From the foregoing Findings of Fact, the Court enters the following:

CONCLUSIONS OF LAW

1. Jurisdiction and venue are proper in this Court.

2. By using the limiting term "ultra" in the phrase "ultra-fast-acting barbiturate" in Montana Code Annotated § 46-19-103(3), the legislature limited the State of Montana to using only drugs in the fastest category of barbiturates, namely thiopental, methohexital, and thiamylal. Under the express terms of the statute, the State of Montana is not allowed to use the "fastest acting barbiturate available," or a "relatively fast-acting barbiturate," only an "ultra-fast-acting barbiturate," meaning drugs from the fastest class of barbiturates.

3. Had the legislature intended to give the State of Montana latitude in what drugs to use, it could have used much more general language in the statute authorizing execution, as many other states have now done. Pentobarbital cannot properly be classified as "ultra-fast-acting," since there is another class of drugs that is faster. Whether those drugs are currently available is not an issue the Court can resolve for the State. The State's remedy is to ask the Legislature to modify the statute to allow the use of pentobarbital or other slower acting drugs.

4. The State of Montana has modified the execution protocol several times during this litigation and has had many opportunities to return to the legislature to modify the language which limits the State of Montana to "ultra-fast-acting barbiturates," but has chosen not to.

5. Courts may not legislate through judicial interpretation of statutes. *Albinger v. Harris*, 2002 MT 118, ¶ 38, 310 Mont 274, 8 P.3d 711 (It is not the province of this court or any other court to assume to legislate by judicial interpretation, and to create in favor of any individual or any class of people an exception to the limitation set by the legislature.). A court cannot second-guess and substitute its judgment for that of the legislature or insert what has been omitted. *State Bar of Mont. v. Krivec*, 193 Mont. 477, 481, 632 P.2d 707, 710 (1981). Indeed, Montana law regarding statutory' interpretation begins with Montana Code Annotated § 1-2-101, which states: [i]n the construction of a statute, the office of the judge is simply to ascertain and declare what is in terms or in substance contained therein, not to insert what has been omitted or to omit what has been inserted." In Montana Code Annotated § 46-19-103, the legislature mandates use of an "ultra-fast-acting barbiturate," and the Department of Corrections plan to use a drug which is, without dispute, not classified as an ultra-fast-acting barbiturate. Given these facts, the Court must find an impermissible inconsistency between the legislative mandate and the Department of Corrections' exercise of that mandate. Scrupulous adherence to statutory mandates is especially important here given the gravity of the death penalty. *Accord* *In re Ohio Execution Protocol Litigation*, 840 F. Supp. 2d 1044 (S.D. Ohio 2012).

From the foregoing Findings of Fact and Conclusions of Law, the Court enters the following:

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ORDER

***6** The State of Montana is hereby ENJOINED from using the drug pentobarbital in its lethal injection protocol unless and until the statute authorizing lethal injection is modified in conformance with this decision.

DATED this *6* day of October 2015.

<<signature>>

JEFFREY M. SHERLOCK

District Court Judge

pcs: Ronald F. Waterman

Jim Taylor

Gregory A. Jackson

Michael Donahoe

Timothy C. Fox/C. Mark Fowler/Pamela P. Collins/Jonathan M. Krauss, Robert Stutz

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SOUTH DAKOTA PENITENTIARY

KITE - REQUEST SLIP

October 1, 2019 20____

Inmate RHINES, Charles No. 15036

Cell No. A-3-55 Works Pending

Desires an Audience with DARIN YOUNG: Warden: South Dakota State Penitentiary

Give Reason — Private Business Not Sufficient

As per South Dakota Codified Law 23A-27A-32.1, I am hereby notifying you that I have selected the method of execution which was in effect at the time I was sentenced to death:

To: Wit: January 29, 1993

Charles R. Rhines

STATE OF SOUTH DAKOTA
COUNTY OF MINNEHAHA

On October 1, 2019, Charles R. Rhines personally appeared before me, whose Identity I proved on the basis of Incarceration, to be the signer of the above document, and he acknowledged that he signed it.

NOTARY PUBLIC

My Commission Expires: 5/04/20

S E A L

KEITH A. THANSON
NOTARY PUBLIC
SOUTH DAKOTA

OFFICER

SECOND ITTERATION, SUPERCEDES ALL OTHERS NOT SO MARKED_

SOUTH DAKOTA PENITENTIARY

KITE - REQUEST SLIP

October 4, 2019 20 _____

Inmate RHINES, Charles, R. No. 15036

Cell No. A-3-55 Works Pending

Desires an Audience with DARIN YOUNG: Warden: South Dakota State penitentiary

Give Reason — Private Business Not Sufficient

As per South Dakota Codified Law 23A-27A-32.1, I am hereby notify-you that I have selected the method of execution which was in effect at the time I was sentenced to death on January 29, 1993. To Wit: The Two Drug Protocol of a Lethal Dose of An Ultra-short Acting Barbiturate and a Chemical paralytic agent.

Charles R. Rhines

STATE OF SOUTH DAKOTA
COUNTY OF MINNEHAHA

On October 4, 2019, Charles R. Rhines personally appeared before me, whose Identity I proved on the babsis of Incarceration, to be the signer of the above document, and he acknowledged that he signed it.

S E A L NOTARY PUBLIC

My Commission Expires: 7-17-2024

TAYLOR YOST
NOTARY PUBLIC SOUTH DAKOTA
SEAL OFFICER SEAL
My Commission Expires 7-17-24

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GT GreenbergTraurig

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October 15, 2019

VIA EMAIL AND USPS

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Sioux Falls, South Dakota 57117

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Paul Swedlund, Esq.
Assistant Attorney General
1302 East Highway 14, Suite 1
Pierre, South Dakota 57501

Re: Charles Rhines, SDDOC #15036

Dear Warden Young and Mr. Swedlund:

We represent Charles Russell Rhines. As you know, on June 25, 2019, Judge Robert Mandel issued a warrant of execution for Mr. Rhines for between November 3 and November 9, 2019. Pursuant to S.D.C.L. § 23A-27A-32.1, on a Kite-Request Slip dated October 1, 2019 and an amended Kite-Request Slip dated October 4, 2019, Mr. Rhines elected to be executed pursuant to the manner provided by South Dakota law at the time of his sentence; to wit, "by the intravenous administration of a lethal quantity of an ultra-short acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced dead by a licensed physician according to accepted standards of medical practice." SL 1984, ch 181.

We write to request that you confirm Mr. Rhines's request will be honored, and that he will be executed by the intravenous administration of an ultra-short-acting barbiturate. We also request that you identify which one of the three ultra-short-acting barbiturates will be used to execute Mr. Rhines: sodium methohexital; sodium thiamylal, or; sodium thiopental.

Further, with respect to the ultra-short-acting barbiturate that is identified for use in Mr. Rhines's execution, we request that you provide the following information: (1) whether it was manufactured or compounded; (2) if manufactured, the identity of the country, or the State in the United States, from whence it was imported/obtained; (3) if compounded, the date on which any compounding was performed and whether it was performed by a licensed pharmaceutical company or pharmacist; (4) any testing conducted to ensure such drug's or drugs' (including the API) potency, purity, and integrity, including the tests conducted, the date(s) of same, and the results; (5) whether

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such testing was performed by a licensed pharmaceutical company, pharmacy, or pharmacist, and whether such pharmaceutical company, pharmacy, or pharmacist has been subject to disciplinary action or cited for violations of state or federal laws or regulations by either state or federal entities; (6) the "beyond use" or "expiration" date of such drug (including the API), and when and how such date(s) was/were established; (7) the date on which any API was ordered and received and how it was stored during transport and since it has been in DOC's possession, and; (8) how the drug has been stored since the time of compounding or importation.

We also request that you confirm a licensed physician will be present at Mr. Rhines's execution to pronounce death.

Please provide this information no later than October 18, 2019 to my email address, hellerc@gtlaw.com. I look forward to your timely response.

Sincerely,

/s/ Caroline J. Heller

Caroline J. Heller
Greenberg Traurig, LLP
200 Park Ave.
New York, New York 10166
Telephone (212) 801-2165
Facsimile (212) 805-9488
hellerc@gtlaw.com

cc: Jason Ravnsborg, Esq. (*via email and U.S. Mail*)
Charles Rhines (*via U.S. Mail*)

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STATE OF SOUTH DAKOTA

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JASON R. RAVNSBORG
ATTORNEY GENERAL

CHARLES D. McGUIGAN
CHIEF DEPUTY ATTORNEY GENERAL

October 17, 2019

VIA EMAIL AND USPS

Caroline Heller
GreenbergTraurig, LLP
MetLife Building
200 Park Avenue,
New York NY 10166
hellerc@gtlaw.com

Dear Ms. Heller:

I am in receipt of your letter regarding Mr. Rhines' request for execution pursuant to the combination of drugs provided by statute at the time of his execution. The DOC will follow the law. The ultra-short acting barbiturate the state intends to use is pentobarbital.

Recent case authorities have quite emphatically and unequivocally stated that "[n]either the 5th, 14th or 1st Amendments afford [inmates] the broad right 'to know where, how and by whom the lethal injection drugs will be manufactured," as well as 'the qualifications of the person or persons who will manufacture the drugs, and who will place the catheters." *Wellons v. Georgia Department of Corrections,* 754 F.3d 1260, 1267 (11th Cir. 2014). Consistent with this authority, with regard to your questions related specifically to the pentobarbital:

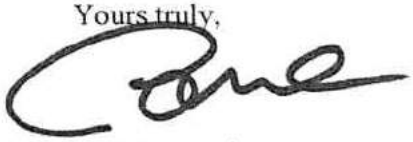
(1) The DOC will not disclose whether the drug is "manufactured" or "compounded." The DOC will advise you that the barbiturate is produced for and used by medical practitioners in the United States. Obviously, drugs used in the United States must be produced in an FDA-approved facility according to accepted GMP.
(2) The DOC will not disclose the country or state of origin of the drug.
(3) No drug has yet been compounded and, consistent with past practice, will not be compounded until 24 hours prior to the execution. Per DOC practice, compounding is performed by qualified persons, as demonstrated by past testing and the efficacy of the drugs in the Robert, Moeller and Berget executions.
(4) The DOC will not disclose testing until after the execution.
(5) Per DOC practice, all testing is performed by a qualified independent lab.

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(6) The DOC will not disclose any "beyond use" or "expiration" date of the drugs it intends to use as this could identify the source. The DOC will advise you that no drug it intends to use is beyond the "beyond use" or "expiration date" set by the manufacturer.
(7) The DOC will not disclose the date any of its drugs were ordered or received.
(8) All drugs have at all times been stored in accordance with manufacturer instructions while in the DOC's control.

Finally, I can confirm for you that a licensed physician will be present at Mr. Rhines' execution.

Yours truly,



Paul S. Swedlund
Assistant Attorney General

PSS/rar

Filed: 10/22/2019 3:36 PM CST Minnehaha County, South Dakota 49CIV19-002940

STATE OF SOUTH DAKOTA	) :SS	IN CIRCUIT COURT
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

CHARLES RUSSELL RHINES, Plaintiff, v. SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, SECRETARY, SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, AND DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY, Defendants.	49CIV. 19-002940 **THIS IS A CAPITAL CASE EXECUTION SET FOR BETWEEN NOVEMBER 3, 2019 AND NOVEMBER 9, 2019**

REPLY/SUPPLEMENTAL MEMORANDUM OF LAW IN FURTHER SUPPORT OF APPLICATION FOR A PRELIMINARY INJUNCTION, TEMPORARY RESTRAINING ORDER AND STAY OF EXECUTION

As this Court identified at the onset of yesterday's hearing, the ultimate issue in this case is whether pentobarbital is an ultra-short-acting barbiturate. Plaintiff Charles Russell Rhines ("Rhines") has demonstrated overwhelmingly that it is not, and no court or medical authority has classified pentobarbital as such. The immediate issue here, however, is whether Plaintiff Rhines has demonstrated a likelihood that pentobarbital is not an ultra-short-acting barbiturate such that a stay of the irreparable is warranted considering the other equitable factors. Given such overwhelming demonstration, the Court should answer the immediate issue in the affirmative and grant Rhines' Application for a Preliminary Injunction, Temporary Restraining Order and Stay of Execution.

This brief and supplemental affidavit are submitted pursuant to the Court's invitation to file any additional arguments or information. These supplemental fillings will briefly respond to

some of the arguments raised in Defendants' response to Mr. Rhines's application, as well as provide additional information that it critical to this application.

I. Pentobarbital Is Not an Ultra-Short Acting Barbiturate

As an initial matter, in reviewing the medical documents and testimony regarding barbiturates, the Court should ignore such documents and testimony that relate to the *effects* of the drugs because that is not the issue here. When drafting SDCL § 23A-27A-32 (1984), the legislature set forth a specific *classification* of a barbiturate to be used - those classified as ultra-short-acting. The statute did not concern itself the effects of drugs nor did it defer to the South Dakota Department of Corrections to choose the drugs and the doses to accomplish the desired effects. With no authority classifying pentobarbital as an ultra-short-acting barbiturate and without an expert witness to testify to the same, Defendants attempt to create an alternative classification system based on the effects of the drugs given certain doses and in certain settings rather than the universal classification based on the drugs' chemical properties. To that end, Defendants carefully extract testimony and literature in the context of the effects of barbiturates and not the classification. When looking at the evidence on the classification, which is the exercise here, it is overwhelmingly true that pentobarbital is not an ultra-short-acting barbiturate.

As Dr. Craig Stevens testified and explained, barbiturates are classified as either ultra-short-acting, short-acting, intermediate-acting, or long-acting, depending upon their chemical properties, to wit, how lipid-soluble a particular barbiturate is. He is not aware of any peer reviewed articles or medical literature that has ever classified pentobarbital as an ultra-short-acting barbiturate. He testified that in his expert opinion, pentobarbital is not an ultra-short-acting barbiturate. His opinion is consistent with authoritative medical texts and articles. *See, e.g.*, Linda Lilley, et al., Pharmacology and the Nursing Process 189 (9th ed. 2020) (including classification

chart listing thiopental as ultrashort-acting barbiturate and pentobarbital as short-acting barbiturate); PHARMACOLOGY 111 fig. 9.7 (Richard A. Harvey & Pamela C. Champe eds.) (4th ed. 2009) (classifying pentobarbital as short-acting and thiopental as ultra-short-acting); Carl Burtis et al., Tietz Textbook of Clinical Chemistry and Molecular Diagnostics 1325-26 & Table 34.10 (4th ed. 2006) (identifying thiopental as ultrashort-acting barbiturate and pentobarbital as short-acting barbiturate); Francisco López-Muñoz, et al., The History of Barbiturates a Century After Their Clinical Introduction, NEUROPSYCHIATRIC DISEASE AND TREATMENT, Vol. 1(4), 329-43, Table 3 (Dec. 2005) (reproducing table from 1983 classifying pentobarbital as short-acting and thiopental as ultrashort-acting); *see also* 1 Lawyers' Guide to Medical Proof § 106.02 (2019) (classifying ultrashort-acting barbiturates "in current medical use" as methohexital, thiamylal, and thiopental, and classifying pentobarbital among the short-acting and intermediate-acting barbiturates); 9 Attorneys Textbook of Medicine (Third Edition) P. 51.10 (2019) (classifying ultrashort-acting barbiturates as thiopental, thiamylal and methohexital); 12-256-9A Courtroom Medicine Series: Psychic Injuries § 9A.50 ("Ultra-short-acting barbiturates include thiopental (half-life of 6 to 46 hours; Schedule III) and methohexital (1 to 2 hours; Schedule IV); the short-acting group includes pentobarbital (Nembutol; 15 to 48 hours; Schedule II; III) . . . .").

The affidavit of Dr. Antiognini, submitted by the Defendants, does not contradict this.[1] Rather than arguing against the universally-accepted classification of pentobarbital, Dr. Antiognini focuses on the "desired clinical effect (e.g. unconsciousness)" of pentobarbital compared to other drugs at different doses. See Ex. D to Antiognini affidavit. In other words, Dr. Antiognini cannot

[1] If Defendants submit a supplemental affidavit from Dr. Antognini that states that pentobarbital has been classified as an ultra-short-acting barbiturate, this Court should grant the motion for an injunction to allow counsel for Mr. Rhines to depose Dr. Antiognini. The crux of the complaint and motion are whether pentobarbital is classified as an ultra-short-acting barbiturate, and if Dr. Antiognini did not testify to that in his first affidavit, counsel for Mr. Rhines is entitled to test any newly formed opinion.

argue against the chemical properties of pentobarbital, namely its lipid-solubility, that prevent it from being classified as ultra-short-acting and, instead, argues a position not contemplated by SDCL § 23A-27A-32 (1984) – that, if the warden gets the dose right, it will have the effect of unconsciousness at the same rate as an ultra-fast-acting barbiturate.

Based on their carefully extracted phrases from medical literature and expert testimony, defendants attempt to create a narrative that medical minds can differ on the chemical properties of barbiturates and the classifications based thereon, particularly, anesthesiologists. To the contrary, the Court in *Smith v. Montana*, No. BDV-2008-303, 2015 WL 5827252, at *1 (Mont. Dist. Ct. Lewis and Clark County Oct. 6, 2015), cites Margaret Wood and Alistair J.J. Wood's text, "DRUGS AND ANESTHESIA PHARMACOLOGY FOR ANESTHESIOLOGISTS" (2d. ed.,Williams & Wilkins 1989), in support of the statement that "[b]arbiturates are traditionally classified as long-acting (phenobarbital), medium-acting (such as pentobarbital), short-acting (secobarbital), and ultra-short-acting (thiopental)." *Smith*, 2015 WL 5827252, at *2. In their response, Defendants cited an article on neurosurgical anesthesia to support their argument, *see* Response Mot. Prelim. Inj. 14, but that article itself recognizes that pentobarbital is not an ultra-short-acting barbiturate: "[L]ittle is known about the hemodynamic effects of pentobarbital in humans, at least when given in the doses needed for neurosurgical purposes. *This contrasts with the large body of data concerning the effects of the ultrashort-acting anesthetic barbiturates such as thiopental*."). Todd, Drummond and Sang, Hemodynamic Effects of High Dose Pentobarbital: Studies in Elective Neurosurgical Patients, 20 NEUROSURGERY 559 (1987) (emphasis added).

Other authorities specific to the field of anesthesiology and outside the field of pharmacology likewise classify pentobarbital as a short-acting barbiturate. *See, e.g.*, Helen Lamb, The barbiturates: with particular reference to their use in anesthesia. Bulletin of the American

Association of Nurse Anesthetists. 1943;12(4): 228-29 (identifying pentobarbital as a barbiturate "of moderate duration" while identifying evipal, pentothal, and thio-ethymal as "ultra-short-acting barbiturates"); Torben Seear, Pentobarbital Anesthesia in Labor, M.D. AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, Vol. 99, Issue 7, p. 955 (Dec. 1967) ("Pentobarbital is a short-acting, but not ultrashort-acting barbiturate."); Peter D. Bryson, *Comprehensive Review in Toxicology for Emergency Clinicians* 464 (3d. ed. 2018) (classifying Pentobarbital in the "Short – and Intermediate-acting" Barbiturate classification as opposed to the "Ultrashort-acting" classification); Sandra J. Cunningham & Waseem Hafeez, "Procedural Sedation and Pain Management Techniques," Textbook of Pediatric Emergency Procedures 423 (Christopher King & Fred M. Henretig eds., 2d ed. 2008) (identifying pentobarbital as "a short-acting barbiturate," as opposed to methohexital which is an "ultrashort-acting barbiturate").

Further, manufacturers of pentobarbital refer to it as a short-acting barbiturate. Not only does the FDA-approved branded manufacturer's insert for Nembutal Sodium Solution, which is the manufacturer's name for pentobarbital, state: "NEMBUTAL Sodium is a short-acting barbiturate," (Fritz Exh. 4), but the manufacturers for generic pentobarbital, Sagent and Leucadia, similarly state that pentobarbital is a short-acting barbiturate. *See* https://www.sagentpharma.com/wp-content/uploads/2017/11/Pentobarbital_PI-Revised.pdf; http://leucadiapharma.com/wp-content/uploads/2018/02/Pentobarbital_PI_Art_Clean.pdf.

The State repeatedly mischaracterizes testimony on the classification of barbiturates from a different expert, Dr. Mark Heath, in different litigation. Dr. Heath's testimony supports Rhines's position. Dr. Heath used the terms "ultra-short" and "ultra-fast" interchangeably, and he consistently referred to that category of barbiturates in "*contrast*" with pentobarbital. *Compare* State's Exhibit 8 at transcript page 21–22 ("I'll just start by comparing ultra-short and ultra-fast-

acting barbiturates which will enter the brain very quickly in a matter of tenths of seconds, and will also leave the brain very quickly . . . . and those drugs would be the class of drug would be thiopental, for example, and another would be a drug called methohexital."), *with id.* at transcript page 22 ("*By contrast*, pentobarbital is slower to take effect and lasts for longer." (emphasis added)). The State pulls quotations out of context, but even these quotations never establish that this different expert classified pentobarbital as "ultra-short-acting." *See, e.g.*, State's Exhibit 11 at transcript page 90 (explaining that the line dividing ultrafast from fast-acting barbiturates "is really a molecular line. . . . . [Molecular] modifications have created a class unto itself."). The State goes so far as to repeatedly cite the expert's testimony in *Smith*, the very premise of which was that pentobarbital is not an ultra-short-acting barbiturate. Thus, that there are "different ways" to classify barbiturates does not change that Dr. Heath never placed pentobarbital in any sort of "ultra-short" or "ultra-fast" category. *See* State's Exhibit 8 at transcript page 21.

Consistent with this evidence, numerous cases have recognized that pentobarbital is not a short-acting barbiturate. *See McGehee v. Texas Dep't of Criminal Justice*, No. MC H-18-1546, 2018 WL 3996956, at *2 (S.D. Tex. Aug. 21, 2018) ("Testimony in other cases has established that pentobarbital is 'not classified as an ultra-short-acting barbiturate.' *Mann v. Palmer*, 713 F.3d 1306, 1313 (11th Cir. 2013)."); *Bible v. Davis*, No. 4:18-CV-1893, 2018 WL 3068804, at *1 (S.D. Tex. June 21, 2018) ("Pentobarbital is an intermediate-acting barbiturate") (internal quotation omitted), aff'd, 739 F. App'x 766 (5th Cir. 2018); *West v. Schofield*, 519 S.W.3d 550, 553 (Tenn. 2017) (stating that pentobarbital is "described in [Tennessee's execution] Protocol as 'an intermediate-acting barbiturate'") (internal brackets omitted); *Grayson v. Warden, Comm'r, Alabama DOC*, 869 F.3d 1204, 1210 (11th Cir. 2017) (describing "pentobarbital, [as] a short-acting barbiturate sedative") (internal quotation marks omitted); *West v. Warden, Comm'r,*

Alabama DOC, 869 F.3d 1289, 1292 (11th Cir. 2017) (describing "pentobarbital, [as] a short-acting barbiturate sedative") (internal quotation marks omitted); *Whitaker v. Livingston,* No. CV H-13-2901, 2016 WL 3199532, at *1 (S.D. Tex. June 6, 2016) ("Pentobarbital is an intermediate-acting barbiturate."), *aff'd sub nom. Whitaker v. Collier,* 862 F.3d 490 (5th Cir. 2017); *Smith v. Montana,* No. BDV-2008-303, 2015 WL 5827252, *2 (Oct. 6, 2015) ("Barbiturates are traditionally classified as long-acting (phenobarbital), medium-acting (such as pentobarbital), short-acting (secobarbital), and ultra-short-acting (thiopental).") (Exh. A to the Compl.); *Williams v. Com., Dep't of Corr*., No. 353 M.D. 2014, 2015 WL 6474764, at *5 (Pa. Commw. Ct. Oct. 15, 2015) (considering challenge to inclusion of pentobarbital in execution protocol under statute requiring execution with "an ultrashort-acting barbiturate" and "chemical paralytic agents" and concluding: "taking Petitioners' allegation that pentobarbital and potassium chloride are neither ultrashort-acting barbiturates nor chemical paralytic agents as true, Petitioners have stated a claim that the Protocol violates the statute."); *Trottie v. Livingston,* No. CV 4:14-2550, 2014 WL 12527181, at *2 (S.D. Tex. Sept. 5, 2014) ("pentobarbital . . . is an intermediate-acting barbiturate.") (internal quotation omitted); *Arthur v. Thomas,* 974 F. Supp. 2d 1340, 1345 (M.D. Ala. 2013) ("Sodium thiopental is classified as an 'ultra-short acting barbiturate,' while pentobarbital is an 'intermediate-acting barbiturate.' As these classifications indicate, sodium thiopental has an extremely rapid onset of effect and subsequent recovery, while pentobarbital is slower and longer-acting."); *Arthur v. Thomas*, 674 F.3d 1257, 1274 (11th Cir. 2012) ("sodium thiopental is 'ultrashort-acting,' while pentobarbital is 'intermediate-acting'") (internal quotation and citation omitted); *Powell v. Thomas*, 643 F.3d 1300, 1304 (11th Cir. 2011) ("sodium thiopental is 'ultrashort-acting,' while pentobarbital is 'intermediate-acting'") (internal quotation and citation omitted); *In re Jacoby Airplane Crash Litig*., No. CIV.99-6073 (HAA), 2007 WL 5037683, at *22

(D.N.J. Aug. 27, 2007) ("The ultrashort-acting barbiturates produce anesthesia within about one minute after intravenous administration.... Barbiturate abusers prefer the Schedule II short-acting and intermediate-acting barbiturates that include amobarbital (Amyta®), pentobarbital (Nembutal®), secobarbital (Seconal®), and Tuinal (an amobarbital/secobarbital combination product).") (internal quotation and citation omitted). Nearly all of these cases arose in the lethal injection context thus belying Defendants' suggestion that pentobarbital's classification changes to ultra-short-acting when it is used in lethal doses for execution.

Defendants cite cases in their response that, they claim, state that there is no difference between sodium thiopental and pentobarbital. As described during the hearing, those cases arose in the context of Eighth Amendment challenges focused on various execution protocols' likelihood to produce unnecessary suffering. not one of them states that pentobarbital is classified as an ultra-short-acting barbiturate, the only issue before this Court. In fact, undersigned counsel is aware of no case that identifies pentobarbital as an ultra-short-acting barbiturate.

The plain language of the statute at issue here is clear. Just as the Court held in the *Smith* case, had the legislature intended to give the State of South Dakota latitude in what drugs to use, it could have used much more general language in the statute authorizing execution. Instead of "ultra-short-acting barbiturate" the legislature could have said "barbiturates in doses that have the effect of ultra-short-acting barbiturates." Courts may not legislate through judicial interpretation of statutes and the Court should not second-guess and substitute its judgment for that of the legislature, or insert what the legislature omitted.

II. As a Matter of Law, This Action Was Timely Brought And The Application Should Not Be Denied on the Basis of Defendants' Equitable Interest in Having Rhines Executed Next Week.

This action was not ripe until weeks ago and was timely brought within the time-frame set forth in SDCL § 23A-27A-32.1. That fact that Rhines was sentenced many years ago or the fact that he has litigated different rights previously over the years is of no consequence here. What matters here is that this action was not ripe until Rhines was informed that the DOC would be using pentobarbital and that he brought it more than seven days prior to his scheduled week of execution.

Whether an issue could have been properly litigated in an earlier action requires consideration of whether the issue actually had been ripe for determination at the time of that earlier action. *See State v. Hammerquist*, 67 S.D. 417, 293 N.W. 539, 541 (S.D. 1940) (declining to apply res judicata, noting "[a]t the time of hearing and decision resulting in the order, *that which was originally conditional had ripened* into an order setting the state's judgment aside" (emphasis added)); *Danforth v. City of Yankton*, 25 N.W.2d 50 (S.D. 1946) ("The case was submitted upon the assumption that there existed a controversy properly determinable under the Declaratory Judgment Law. If there was an absence of jurisdiction in the trial court to consider the questions presented, the declarations are advisory only and would not be res judicata.").

Ripeness involves the timing of judicial review and the principle that the judicial machinery should be conserved for problems that are real and present, not squandered on problems that are abstract, hypothetical, or remote. *Steinmetz v. State, DOC Star Academy*, 756 N.W.2d 392, 399 (S.D. 2008). Courts should not render advisory opinions or decide theoretical questions when the future shows no indication of the invasion of a right. *Id.*; *Boover v. South Dakota Bd. Of Accountancy*, 526 N.W.2d 747, 750 (SD 1995).

Here, Mr. Rhines could not have properly raised this issue in any prior litigation. Prior litigation focused on whether the 2007 statutory amendments and the August 2011 protocol complied with the Eighth Amendment standards as set forth by the United States Supreme Court in *Baze v. Rees*, 533 U.S. 35 (2008). *See* Feb. 27, 2013, Op., Trimble, J.at 8. Judge Trimble determined that the protocol was sufficiently similar to *Baze* that it was constitutional on its face, *id.* at 10–12, and that South Dakota would implement its protocol in a constitutional manner. *Id.* at 12–18.

There were no facts or issues relating to the statute in effect at the time of Mr. Rhines's sentencing or the use of an ultra-short-acting barbiturate. And for good reason. In 2011, there was no reason to believe that the State would not abide by the statutory requirement that, if elected, the state would deliver a lethal dose of an ultra-short acting barbiturate and chemical paralytic agent. The State possessed sodium thiopental, an ultra-short-acting barbiturate, and there was no reason to believe that the State would not use that drug in compliance with the statutory mandate.

Thus, at the time of the prior litigation, there was no concern that the State would choose to disregard the statutory mandate. The issues became ripe on October 17, 2019, when, in response to Mr. Rhines's election within the statutory timeline and under an active warrant, the State announced that it would use pentobarbital instead of the mandated ultra-short-acting barbiturate. Prior to that date, any issue concerning the use of pentobarbital in place of an ultra-short-acting barbiturate would have been speculative, abstract, and remote, and not the subject of judicial review. Res judicata does not apply.

Dated this 30th day of October, 2019.

BALLARD SPAHR LLP

By: /s/ Daniel R. Fritz

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STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	:SS	
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

CHARLES RUSSELL RHINES, Plaintiff, v. SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, SECRETARY, SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, AND DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY, Defendants.	CIV. 19-002940 **THIS IS A CAPITAL CASE EXECUTION SET FOR BETWEEN NOVEMBER 3, 2019 AND NOVEMBER 9, 2019**

AFFIDAVIT OF DANIEL R. FRITZ

STATE OF SOUTH DAKOTA)
:SS
COUNTY OF MINNEHAHA)

Daniel R. Fritz, being first duly sworn on oath, states and alleges as follows:

1. I am an attorney for Plaintiff Charles Russell Rhines in the above-captioned case, and I have knowledge of the matters herein.
2. Attached hereto as Exhibit 1 is a true and correct copy of selected pages from 1 Lawyers' Guide to Medical Proof § 106.02 (2019).
3. Attached hereto as Exhibit 2 is a true and correct copy of selected pages from 9 Attorneys Textbook of Medicine (Third Edition) P. 51.10 (2019).
4. Attached hereto as Exhibit 3 is a true and correct copy of selected pages from Peter D. Bryson, Comprehensive Review in Toxicology for Emergency Clinicians (3d. ed. 2018).

5. Attached hereto as Exhibit 4 is a true and correct copy of selected pages from Francisco López-Muñoz, et al., The History of Barbiturates a Century After Their Clinical Introduction, NEUROPSYCHIATRIC DISEASE AND TREATMENT, Vol. 1(4) (Dec. 2005).

6. Attached hereto as Exhibit 5 is a true and correct copy of selected pages from Torben Seear, Pentobarbital Anesthesia in Labor, M.D. AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, Vol. 99, Issue 7 (Dec. 1967).

7. Attached hereto as Exhibit 6 is a true and correct copy of selected pages from Linda Lilley, et al., Pharmacology and the Nursing Process (9th ed. 2020).

8. Attached hereto as Exhibit 7 is a true and correct copy of selected pages from PHARMACOLOGY (Richard A. Harvey & Pamela C. Champe eds.) (4th ed. 2009).

9. Attached hereto as Exhibit 8 is a true and correct copy of selected pages from Sandra J. Cunningham & Waseem Hafeez, "Procedural Sedation and Pain Management Techniques," Textbook of Pediatric Emergency Procedures 423 (Christopher King & Fred M. Henretig eds., 2d ed. 2008).

10. Attached hereto as Exhibit 9 is a true and correct copy of selected pages from Carl Burtis et al., Tietz Textbook of Clinical Chemistry and Molecular Diagnostics 1325-26 & Table 34.10 (4th ed. 2006).

11. Attached hereto as Exhibit 10 is a true and correct copy of selected pages from Subcommittee on Anesthesia of National Research Council, Fundamentals of Anesthesia: An Outline 38 (American Medical Association Press 1942).

Dated this 30th day of October 2019.

Daniel R. Fritz

Subscribed and sworn to before me this 30th day of October, 2019.

(SEAL)

JUDY L. DECKER
Notary Public
SEAL
South Dakota

Notary Public – South Dakota

3/7/24

EXHIBIT 1

§ 106.02 Glossary of Prescription and Non-Prescription Drugs

-A-

Abacavir Sulfate. The FDA approved this drug in September 2008. It sold under the trademark Ziagen®, and is used in combination with other antiretroviral medications to treat HIV-1 infection. Abacavir Sulfate belongs to the class of drugs known as nucleoside reverse transcriptase inhibitors. The following reactions may indicate allergy or hypersensitivity to Abacavir Sulfate: skin rash, fever, nausea, vomiting, diarrhea, severe fatigue, severe achiness, sore throat, dyspnea, cough, pharyngitis or shortness of breath. If these symptoms are ignored, more severe symptoms may follow sometimes within hours, including life-threatening low blood pressure and death. This drug can also cause a condition called lactic acidosis, which, together with an enlarged liver, can be fatal. Because resistance to the HIV virus can occur quickly with single-drug treatment, Abacavir should be taken in combination with other antiretroviral medications and should never be taken alone to treat HIV.

Acetaminophen. Acetaminophen (N-acetyl-p-aminophenol; APAP; paracetamol) was clinically introduced in 1955 and has since become the most widely used over-the-counter analgesic-antipyretic in the United States. The drug is indicated for a wide variety of arthritic and rheumatic conditions involving musculoskeletal pain, as well as other painful disorders such as headaches and menstrual cramps. Acetaminophen is also recommended for the discomfort, common cold fevers, and other viral infections.

Lay people commonly underestimate acetaminophen’s toxicity. For decades the drug was thought rarely to produce any side effects except for liver toxicity in patients who take excessive doses for an extended period of time. In 2001, however, researchers at the University of Texas Southwestern Medical Center in Dallas released a report suggesting that overdoses of acetaminophen could pose a greater risk of liver failure than several other prescription drugs that were removed from the market due to rates of liver toxicity.

Many consumers are unaware that many prescribed and over-the-counter medications contain some amount of acetaminophen thereby increasing the risk of accidental overconsumption of the drug. In March 2014, in effort to reduce the risks of inadvertent acetaminophen overdose, the FDA issued Federal Register notices that formally withdrew applications for all prescription drugs containing more than 325mg of acetaminophen per tablet, capsule, or other dosage unit. Manufacturers of previously approved products that contain more than 325mg discontinued marketing for those products while any pending applications for approval were voluntarily withdrawn in compliance with the FDA’s request (FDA, 2014).

Acetaminophen with Codeine, Hydrocodone, Propoxyphene, or Oxycodone. Acetaminophen (e.g., Tylenol®) with codeine is used to treat mild to severe pain. Some of the side effects are constipation, nausea, drowsiness, anxiety, difficulty breathing, palpitations, rash, fever and sore throat, unusual bleeding or bruising and jaundice. Extreme drowsiness may result if taken with alcohol, antihistamines, barbiturates, Benzodiazepine tranquilizers, or tricyclic antidepressants. Liver damage may occur when taken with anticonvulsant drugs, barbiturates, and alcohol. Some individuals self-administer of acetaminophen with codeine to get “high.” The product, therefore, should be kept away from individuals that have a history of substance abuse.

Acetazolamide. This drug, sold under the trade names Diamox® and Sequels®, is used to treat glaucoma, epilepsy and edema. Its major side effects may include back pain, black tarry stools, blurred vision, convulsions, difficulty urinating, fever, rash, jaundice or unusual bleeding or bruising, upset stomach, vomiting, and loss of

occur in elderly patients. Occasional hypersensitivity reactions have been observed, especially skin rashes which in some instances progressed to exfoliation.

Azathioprine (Azasan, Imuran). Patients are prescribed Azathioprine to protect against rejection of transplanted organs and to treat severe, active rheumatoid arthritis and other immunologic diseases. Possible adverse reactions include rapid heart rate, sudden fever, muscle or joint pain, cough, shortness of breath, infection or low blood count causing fever and chills, back pain, cough, painful urination, anemia, vomiting, appetite loss, jaundice, low platelet count causing bleeding or bruising, tarry or black stools, bloody urine, red spots under the skin, severe abdominal pain and mouth sores.

Use of azathioprine with other drugs may have severe consequences, especially allopurinol (increasing azathioprine activity), clozapine (potentially causing a toxic effect on bone marrow), tiopronin (increasing the risk of toxicity to bone marrow), immunosuppressants (increasing the risk of infection or malignancies), and vaccines (potentially decreasing effectiveness of vaccine or cause the disease itself).

Azathioprine may increase the risk of developing certain types of cancer, especially skin cancer and lymphoma (cancer that begins in the cells that fight infection). In kidney transplant patients, there may be a higher risk of developing cancer even for patients who do not take azathioprine. Azathioprine can cause a decrease in the number of blood cells in the bone marrow, which may cause serious or life-threatening infections. That risk is highest in patients who have a genetic (inherited) risk factor.

Azithromycin (Zithromax, Zmax). Azithromycin is an antibiotic used for respiratory tract infections and sexually transmitted diseases. Its major side effects include fever, palpitations, rash, swelling of the neck or face, jaundice, and shortness of breath. Azithromycin interacts with aminophylline, theophylline, carbamazepine, cyclosporin, phenytoin, digoxin, triazolam, phenobarbital, ergotamine, dihydroergotamine and blood thinners. Use with antacids decreases its effectiveness.

A 2012 study reported an increased number of cardiovascular-related deaths as well as an increased risk of death from unknown causes among individuals that were treated with a 5-day course of azithromycin (Zithromax) compared to individuals treated with amoxicillin or ciprofloxacin (Ray, et al., 2012).

-B-

Balsalazide (Colazal). The FDA approved Balsalazide in July 2000 under the brand name Colazal®. Balsalazide, is used to treat ulcerative colitis, a condition in which the bowel is inflamed. Balsalazide is an anti-inflammatory drug. It is converted in the body to mesalamine and works by reducing bowel inflammation, diarrhea, rectal bleeding, and stomach pain.

Side effects from balsalazide can occur such as: headache, abdominal pain, upset stomach, diarrhea, vomiting, joint pain, difficulty falling or staying asleep, tiredness, gas, runny nose, muscle or back pain, coughing, loss of appetite, urinary tract infection, constipation, or dry mouth. More serious side effects include yellowing of skin or eyes, dark urine, stomach bloating or swelling, increased diarrhea, rectal bleeding, fever, sore throat, or flu-like symptoms.

Barbiturates. Barbiturates are a class of drugs prescribed in low doses to reduce anxiety, nervous tension, or to aid sleep. Barbiturates produce a wide spectrum of central nervous system depression, from mild sedation to coma, and have been used as sedatives, hypnotics, anesthetics, and anticonvulsants. The primary differences among many of these products are how fast they produce an effect and how long those effects last. Barbiturates are classified as ultrashort, short, intermediate, and long acting. Higher dosages are used to reduce the likelihood of seizures in persons with epilepsy. An overdose of barbiturates may cause deep sleep, difficulty breathing, coma and weak pulse.

In rare cases, barbiturates may cause agitation, slow heartbeat, difficulty breathing, jaundice, and chest pain. Other more common side effects include unexplained bleeding or bruising, dizziness, drowsiness, “hangover,” rash or

hives on face or lip and eyelid swelling, sore throat, fever, depression, confusion, diarrhea, nausea, vomiting, joint or muscle pain, slurred speech, hallucinations and headache.

The ultrashort-acting barbiturates produce anesthesia within about one minute after intravenous administration. Those in current medical use are the Schedule IV drug methohexital (Brevital®), and the Schedule III drugs thiamylal (Surital®) and thiopental (Pentothal®). Barbiturate abusers prefer the Schedule II short-acting and intermediate-acting barbiturates that include amobarbital (Amytal®), pentobarbital (Nembutal®), secobarbital (Seconal®), and Tuinal (an amobarbital/secobarbital combination product). Other short and intermediate-acting barbiturates are in Schedule III and include butalbital (Fiorinal®), butabarbital (Butisol®), talbutal (Lotusate®), and aprobarbital (Alurate®). After oral administration, the onset of action is from 15 to 40 minutes, and the effects last up to six hours. These drugs are primarily used for insomnia and preoperative sedation. Veterinarians use pentobarbital for anesthesia and euthanasia.

Long-acting barbiturates include phenobarbital (Luminal®) and mephobarbital (Mebaral®), both of which are in Schedule IV. Effects of these drugs are realized in about one hour and last for about 12 hours, and are used primarily for daytime sedation and the treatment of seizure disorders.

Belladonna. Belladonna is used to reduce spasms of the digestive system, bladder and urethra. Possible adverse reactions or side effects include confusion, delirium, rapid heartbeat, nausea, vomiting, decreased sweating, constipation, rash or hives, eye pain, blurred vision and lightheadedness.

Use with other drugs may increase or decrease the effectiveness of belladonna. Although widely regarded as unsafe, belladonna is used as a sedative, to stop bronchial spasms in asthma and whooping cough, and as a cold and hay fever remedy. It is also used for Parkinson's disease, colic, motion sickness, and as a painkiller.

Benazepril (Lotensin®). Benazepril (Lotensin®) is an angiotensin-converting enzyme (ACE) inhibitor designed to treat high blood pressure. The drug may be contraindicated in patients who are allergic to other ACE inhibitors, as well as patients who have: (1) kidney disease (or who are on dialysis); (2) liver disease; (3) heart disease or congestive heart failure; (4) diabetes; or (5) a connective tissue disease such as Marfan syndrome, Sjögren's syndrome, lupus, scleroderma, or rheumatoid arthritis.

Also, patients should not use this medication without informing their physician if they are pregnant or planning to get pregnant, since the drug can cause birth defects if taken during pregnancy. It can also pass into breast milk and may harm a nursing baby.

Benzodiazepines. Benzodiazepines are a class of drugs used to treat seizure disorders, muscle spasms, nervousness and tension. They may also be prescribed for insomnia. Overdose may result in stupor or coma. Normal doses have side effects that include slow heartbeat, breathing difficulty, hallucinations, confusion, depression, irritability, rash, itchiness, vision changes, dry mouth, sore throat, fever, chills, vivid dreams, behavior changes, abdominal pain and headache. Use of Benzodiazepines in conjunction with other drugs may increase the effects of other drugs, possibly with dangerous results. For example, use with tranquilizers increases the tranquilizer's effect and may dangerously slow down the heartbeat. Use with other anticonvulsants may change the type and severity of seizure activity.

Short-acting benzodiazepines are generally used for patients with sleep-onset insomnia (difficulty falling asleep) without daytime anxiety. Shorter-acting benzodiazepines used to manage insomnia include estazolam (ProSom®), flurazepam (Dalmane®), temazepam (Restoril®), and triazolam (Halcion®). Midazolam (Versed®), a short-acting benzodiazepine, is utilized for sedation, anxiety, and amnesia in critical care settings and prior to anesthesia. It is available in the United States as an injectable preparation and as a syrup (primarily for pediatric patients).

Benzodiazepines with a longer duration of action are utilized to treat insomnia in patients with daytime anxiety. These benzodiazepines include alprazolam (Xanax®), chlordiazepoxide (Librium®), clorazepate (Tranxene®), diazepam (Valium®, halazepam (Paxipam®), lorazepam (Ativan®), oxazepam (Serax®), prazepam (Centrex®), and quazepam (Doral®). Clonazepam (Klonopin®), diazepam, and clorazepate are also used as anticonvulsants.

EXHIBIT 2

Author

Roger Cicala, M.D.
and
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¶ 58.10 GENERAL ANESTHESIA

In providing general anesthesia during a surgical procedure the anesthesiologist is responsible for rendering the patient unconscious and relieving pain. In addition, an important function of the anesthesiologist is to maintain the patient's hemodynamic stability.

General anesthesia involves not only a loss of consciousness but also produces amnesia for the procedure. Either intravenous or inhalation agents can be used for general anesthesia. Often intravenous agents are used for induction of anesthesia because they act very quickly and inhalation agents are used for maintaining anesthesia because they provide better control of the depth of unconsciousness.

Injections of muscle relaxants may be given in order to relax the patient's skeletal muscles which is advantageous in many types of surgical procedures. Also, if a patient needs to be intubated a muscle relaxant is given to facilitate the procedure. Because muscle relaxants paralyze the respiratory muscles, it is critical that before such an agent is given the anesthesiologist is certain that the patient can be adequately ventilated.

During surgery the patient may breathe spontaneously, be assisted with breathing, or have breathing controlled. Breathing can take place either through a mask or an endotracheal (placed inside the trachea) tube. If lengthy controlled breathing is required an endotracheal tube is used and the patient is ventilated mechanically. (*See Figure 58-1.*)

During anesthesia induction and while under anesthesia the patient is carefully monitored. Standards for intraoperative monitoring have been set by the American Society of Anesthesiologists (ASA). One standard requires that when general anesthesia is used someone qualified in anesthesia must be present in the operating room at all times. Another standard requires that a continual evaluation be made of the patient's oxygenation, ventilation, circulation and temperature.

It is extremely difficult to assess the risk of death associated with anesthesia. It is known that the risk is very small, perhaps 1 in 100,000 for a healthy person. The overall mortality appears to be between 1 in 10,000 and 1 in 20,000 (Berthoud and Reilly, 1992). Over the last several decades as improvements in various aspects of anesthesia have occurred the risks have decreased considerably. It is likewise very difficult to assess the risk of serious morbid events associated with anesthesia but such risks are believed to also be very small. On the other hand, potentially serious events requiring intervention by the anesthesiologist do occur.

Although one of the main purposes of general anesthesia is to induce a state of unconsciousness, patients have reported that they were actually aware of what was happening during surgery. In one study of this phenomenon, 26 patients who reported awareness during surgery under general anesthesia were systematically interviewed (Moerman, et al., 1993). The most frequently reported memories were auditory perceptions and the sense of being paralyzed. Many of the patients also reported feeling pain. Feelings of anxiety, panic, powerlessness and helplessness were also commonly reported. Seventy percent of the patients said they had had unpleasant aftereffects such as flashbacks and anxiety during the day and sleep disturbances at night. In another study, 700 patients who underwent surgery involving cardiopulmonary bypass were interviewed postoperatively with regard to their recall of events during the surgical procedure (Phillips, et

cylinders attached to the anesthesia machine. The percentage of each carrier gas in the gas mixture is controlled by flowmeters. The liquid volatile agent is vaporized in a special vaporizer and is added to the carrier gases as they flow through. The process is calibrated so that there is specific volume percent of volatile anesthetic.

The gas mixture is delivered from the anesthesia machine to the patient via a breathing circuit. The most commonly used breathing circuit for adults is known as the circle system. For pediatric patients the Mapleson breathing circuits are used.

The circle system prevents the patient from rebreathing exhaled carbon dioxide, reduces the need for fresh inhalation anesthetic, and keeps the humidity higher. After passing through a chemical absorber in the breathing circuit to remove carbon dioxide, exhaled gases are allowed to pass into the scavenging system which delivers waste gases to a vacuum system. The remaining exhaled air is rebreathed along with freshly delivered gas.

Mapleson breathing circuits do not have an absorber to remove carbon dioxide. In these types of breathing circuits expired gas is washed out by the flow of fresh gas.

The patient may be allowed to breathe spontaneously, if able to, or ventilation may be assisted by compression of the reservoir bag on the anesthesia machine to direct gases into the lungs. Ventilation may also be controlled by a mechanical ventilator. Determination of whether ventilation is adequate is done by auscultation (listening with a stethoscope) of breathing sounds, and checking the reservoir bag or ventilator, and the monitors that are being used. Arterial blood gas analysis may also be needed.

An adequate depth of anesthesia to permit surgery is determined by the application of noxious stimuli. If a painful stimulus does not cause voluntary muscle reflexes or adverse autonomic responses such as hypertension, the depth of anesthesia is considered to be adequate.

The depth of anesthesia should not become too light or too deep. With inadequate anesthesia the patient may respond to surgical stimuli with movement. If the anesthesia is too deep, the patient may exhibit shallow or no respiration, dilated pupils that are not reactive and low blood pressure which may progress to circulatory collapse. If the depth of anesthesia is determined to be too deep steps should be taken immediately to lighten it.

[58.15] Intravenous Anesthetics

The intravenous anesthetics include barbiturates, narcotics, ketamine, benzodiazepines, etomidate and propofol. They are usually used for the induction of general anesthesia. In some cases these agents may be used for maintenance of general anesthesia, either alone or in combination with inhalation agents. When used for maintenance anesthesia these drugs may be given as a steady infusion or as repeated boluses.

[1] Barbiturates

The barbiturates that are given for anesthesia are classified as ultrashort-acting. Specific barbiturates that are used include thiopental, thiamylal and methohexital. These drugs produce anesthesia very quickly as unconsciousness occurs about half a minute after injection. They act fast because they immediately enter the bloodstream and soon thereafter reach the brain. Inhalation anesthetics act much more slowly because they have to be absorbed through the alveoli to enter the bloodstream. Recovery from barbiturate anesthesia is quick and takes about five to ten minutes.

The dosage of barbiturates for anesthesia induction is usually based on the patient’s weight. However, lower doses than normal should be given under special circumstances.

Extreme care must be taken when giving barbiturates intravenously to be sure that the drug does not infiltrate tissues outside of the vein or enter an artery. Severe pain or tissue damage can result because these agents are very alkaline.

Barbiturates should not be given to patients who have had an allergic reaction to a barbiturate. Also, barbiturates are contraindicated in patients who are believed to be at increased risk for porphyria (metabolic disturbances involving porphyrin, a chemical structure that is part of hemoglobin and some other molecules).

[2] Narcotics

Narcotics are not actually total anesthetics because their primary effect is analgesic. Therefore they are most often used as supplements to true anesthetics. In some circumstances, however, when given in high doses they may be used alone for anesthesia.

The narcotics that are frequently used in general anesthesia are morphine, meperidine, fentanyl, alfentanil and sufentanil. The latter two drugs are the most recent to be introduced into clinical practice.

Because sufentanil is a particularly potent analgesic, being about five to ten times as potent as fentanyl, it has become widely used for major surgery. It has been found to reduce the stress responses that occur during anesthesia and seems to be superior to fentanyl for postoperative analgesia (Isaacson, 1992).

Alfentanil, which is only about one fourth as potent as fentanyl, has a particularly short duration of action. Because its effects do not last long it is often used in the ambulatory surgical setting.

Narcotics can cause severe postoperative respiratory and central nervous system depression. However, this can be reversed by a narcotic antagonist, usually the drug naloxone. Because naloxone reverses the effects of narcotics, including the analgesic effects, a patient may experience pain as well as accompanying hemodynamic alterations after it is administered.

[3] Ketamine

Ketamine is an anesthetic that is generally used for induction. Unlike other intravenous agents which cause cardiovascular depression and decreased peripheral resistance with a resulting decline in cardiac output, hypotension, and increase in heart rate, ketamine stimulates the cardiovascular system. Ketamine results in an increase in arterial pressure, cardiac output and heart rate. Ketamine can be given intramuscularly as well as intravenously. This drug produces what is known as a dissociative anesthesia, which means that during recovery from ketamine anesthesia the patient may have vivid and disturbing dreams (Berthoud and Reilly, 1992). The incidence of this phenomenon has been reported to be as high as 30 percent. Only very rarely, however, do these disturbances result in prolonged psychological problems.

[4] Benzodiazepines

Benzodiazepines are generally used as supplementary drugs in general anesthesia but they may also be used for anesthesia induction. These agents produce sedation and amnesia. They have very little analgesic effect. When benzodiazepines are given with narcotics, care must be taken to avoid excessive respiratory depression. There are three benzodiazepines that are used in general anesthesia: diazepam, lorazepam and midazolam. The first two drugs are given orally or via the intravenous route, while midazolam may be given either intravenously or intramuscularly.

The effects of benzodiazepines can be reversed by using the benzodiazepine antagonist flumazenil (Hoffman and Warren, 1993). Flumazenil can reverse sedation, respiratory depression and amnesia. However, since flumazenil has a relatively short half-life resedation may occur after the initial dose. Therefore, in some cases, additional doses may be required.

[5] Etomidate

Etomidate is an intravenous anesthetic that is most often used to induce general anesthesia. Etomidate is classified as a hypnotic (a drug that induces sleep). It does not have analgesic properties. Because its effects on the cardiovascular system are minimal it is often preferred for inducing anesthesia in patients with hemodynamic instability.

[6] Propofol

Propofol is an intravenous anesthetic that became available for clinical use in the United States in 1989. It is used for both anesthesia induction and maintenance and is classified as a sedative/hypnotic (Deegan, 1992). Propofol depresses the central nervous system as well as the cardiovascular and respiratory

EXHIBIT 3

COMPREHENSIVE REVIEW IN TOXICOLOGY for Emergency Clinicians

· THIRD EDITION ·

Peter D. Bryson, M.D.

Comprehensive Review in *Toxicology* for Emergency Clinicians

Third Edition

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Director, Denver Institute of Clinical Toxicology
Denver, Colorado

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TABLE 47–1. *Classification of barbiturates by duration of action*

Ultrashort-acting
Thiopental
Methohexital
Buthabital
Hexobarbital
Thiamylal
Short- and intermediate-acting
Amobarbital
Aprobarbital
Butabarbital
Butalbital
Pentobarbital
Secobarbital
Talbutal
Long-acting
Phenobarbital
Mephobarbital
Metharbital

elimination is primarily by metabolic degradation or excretion, and the rate of removal of the active drug from the central nervous system. On the basis of these differences in the duration of action, barbiturates are classified into three categories: ultrashort-acting, short- and intermediate-acting, and long-acting (Table 47–1) (1). The anticonvulsant primidone (Mysoline) is metabolized to phenobarbital and thus should be considered a barbiturate (4).

Following oral administration, the onset of action varies from 10–30 minutes for amobarbital, aprobarbital, butabarbital, pentobarbital, and secobarbital and from 20–60 minutes for metharbital, mephobarbital, and phenobarbital. There appears to be little difference in duration of the hypnotic action among barbiturates used orally as hypnotics (9). For this reason, barbiturates have recently been grouped according to their intended pharmacologic action, sedative-hypnotic or anesthetic, rather than according to the duration of their action, since classification problems also arose when it was found that the length of time that the drug action persisted did not parallel the time it took to eliminate half the dose of the drug, the elimination half-life. Although the old classification is not used, nothing has been devised to replace it. However, because of the convenience of categorizing barbiturates as to their duration of action, this method is used in this chapter.

The fatal dose of barbiturates with intermediate or short half-lives is usually lower than the fatal dose of drugs with longer half-lives. For example, to induce severe poisoning, it takes less pentobarbital than phenobarbital when they are compared on a milligram-to-milligram basis (3).

Ultrashort-Acting Barbiturates

The ultrashort-acting barbiturates are thiopental, methohexital, buthabital, hexobarbital, and thiamylal (10). These drugs are not a source of abuse, and there should be no occasion to see an overdose with these drugs in an emergency department setting.

Short- and Intermediate-Acting Barbiturates

The short-acting and intermediate-acting barbiturates, such as secobarbital and pentobarbital, are used for induction of general anesthesia. Their relatively swift onset and short duration of action allow for general anesthesia that is rapid and easily reversible. Ease of titration and low acute toxicity in usual doses add to their usefulness (2).

The short- and intermediate-acting barbiturates have an onset of action of 15–40 minutes and a duration of 6 hours. These drugs are the most widely used and abused barbiturates, both separately and in combination. They include, among others, pentobarbital, secobarbital, amobarbital, and butalbital (Table 47–2). Tuinal is a combination of amobarbital and secobarbital and is a favored drug for abuse. Overdoses of the short acting barbiturates have the highest mortality rate (4,11).

Long-Acting Barbiturates

The long-acting barbiturates have an onset of action of approximately 1 hour and a duration of action of up to 16

TABLE 47–2. *Selected trade names of commonly abused barbiturates*

Amobarbital
Amytal
Aprobarbital
Alurate
Butabarbital
Butal
Butalan
Butapan
Butazem
Buticaps
Butisol
Soduben
Butalbital
Florinal
Metharbital
Gemonil
Pentobarbital
Nembutal
PBR/12
Phenobarbital
Luminal
Phen-Squar
Sedadrops
Secobarbital
Seconal
Talbutal
Lotusate

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EXHIBIT 4

The history of barbiturates a century after their clinical introduction

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Abstract: The present work offers an analysis of the historical development of the discovery and use of barbiturates in the field of psychiatry and neurology, a century after their clinical introduction. Beginning with the synthesis of malonylurea by von Baeyer in 1864, and up to the decline of barbiturate therapy in the 1960s, it describes the discovery of the sedative properties of barbital, by von Mering and Fischer (1903), the subsequent synthesis of phenobarbital by this same group (1911), and the gradual clinical incorporation of different barbiturates (butobarbital, amobarbital, secobarbital, pentobarbital, thiopental, etc). We describe the role played in therapy by barbiturates throughout their history: their traditional use as sedative and hypnotic agents, their use with schizophrenic patients in so-called "sleep cures" (Klaesi, Cloetta), the discovery of the antiepileptic properties of phenobarbital (Hauptmann) and their use in the treatment of epilepsy, and the introduction of thiobarbiturates in intravenous anesthesia (Lundy, Waters). We also analyze, from the historical perspective, the problems of safety (phenomena of dependence and death by overdose) which, accompanied by the introduction of a range of psychoactive drugs in the 1950s, brought an end to barbiturate use, except in specific applications, such as the induction of anesthesia and the treatment of certain types of epileptic crisis.

Keywords: barbiturates, history of medicine, sedative-hypnotic drugs, "sleep cures", epilepsy, anesthesia

Introduction

Throughout the history of humanity, numerous therapeutic agents have been employed for their hypnotic and/or sedative properties, though the true effectiveness of many of them has been fairly limited (Alamo et al 1998). It suffices to mention alcohol itself (in different forms, such as hydromel or wine) or the alkaloids of opium and other narcotic plants (hemp, jimsonweed, belladonna, henbane, etc). More recently, around the late 19th and early 20th centuries, agents such as paraldehyde, chloral hydrate, and bromides were used, until the discovery, at the beginning of the 20th century, of the sedative and hypnotic properties of barbiturates, thanks to the prior synthesis of malonylurea by Adolf von Baeyer in 1864.

The clinical introduction of barbiturates begun a century ago (1904) when the Farbwerke Fr Bayer and Co brought onto the market the first agent of this type, diethyl-barbituric acid, giving rise to profound changes in the pharmacological approach to the psychiatric and neurological disorders of the time. A large number of previously untreatable patients gained access to treatment and improved their prognosis. The most significant results were obtained in the treatment of patients with serious neuroses and psychoses and with severe emotional repression, who as a result of being administered barbiturates, especially intravenously, overcame their inhibitions, thus facilitating psychotherapeutic treatment. Barbiturates were also useful in the treatment of sleep disorders as well as being the first truly effective

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pharmacological tools for the management of epileptic seizures. Furthermore, they opened up the field of intravenous anesthesia, playing a prominent role in anesthetic induction, above all for minor operations.

In the course of the 20th century, more than 2500 barbiturates were synthesized, 50 of which were eventually employed clinically. Their use was widespread and many still have some use today. One hundred years after the introduction in clinical pharmacology of the original compound, oxybarbiturates, in general, continue to be the selected drugs in the treatment of some serious forms of insomnia and in some types of epilepsy. Similarly, some thiobarbiturates and some ultrashort-acting barbiturates are still used today as inducers of general anesthesia. Nevertheless, currently, 5 or 6 derivates of barbiturates are sufficient to cover the therapeutic applications that still require them.

Sedative and anticonvulsant drugs in the pre-barbiturate era

Although, as mentioned, the therapeutic agents historically employed for their sedative, hypnotic, or anticonvulsant effects have been quite numerous, the most specific drugs in this regard have their origin in the 19th century. Such is the case of choral hydrate, different alkaloids and, above all, bromides (Hollister 1983; Sneader 1985; Scott 1992; Lehmann 1993; Shorvon and Sander 1996; Shorter 1997; Alamo et al 1998; Healy 2002).

The second half of the 19th century is called by some authors, such as Shorter (1997), the "alkaloids era". Alkaloids were introduced into psychiatry as sedatives and hypnotics, thanks to the isolation of morphine from opium, in 1805, by the German pharmacist Friedrich Sertürner. In 1861, Wilhelm Griesinger, in the second edition of his *Die Pathologie und Therapie der Psychischen Krankheiten*, defended the use of opium in sleep disorders, pointing out the improvements it brought about in patients suffering from anxiety. However, the alkaloids that met with most success were those isolated from different species of the *Solanaceae* family: plants known for their hallucinogenic effects, such as hyoscyamus, whose sedative and hypnotic properties were described by the Viennese pharmacologist Karl Schroff in 1868. In 1839, chemists at the E Merck company in Darmstadt (Germany) had already isolated hyoscyamine, another alkaloid, which became popular in the late 19th century, forming part of many of the "cocktails" administered in neuropsychiatric institutions at that time (Woodward 1994). Finally, the year 1880 saw the isolation of hyoscine (called scopolamine in North America), an alkaloid that was also widely used in psychiatric cocktails, such as the famous Hyoscine Co A, which contained hyoscine, morphine, and atropine, and was administered to highly excited and aggressive manic patients (Norton 1979).

The first drug that could truly be called hypnotic is chloral hydrate. Synthesized in 1832 by Justus von Liebig, a chemist from Giessen, it was not analyzed as a hypnotic until 1869 by the Berlin pharmacologist Oskar Liebreich. The hypothetical mechanism to which its action was ascribed was based on the mistaken belief that, in vivo, chloral hydrate was capable of transforming itself into formic acid and chloroform, whose properties were already known at that time (Sourkes 1992). Very soon, chloral hydrate substituted morphine and the *Solanaceae* alkaloids, given its convenience, as it could be administered without the need for injection, allowing treatment in the home and making it unnecessary to confine patients to neuropsychiatric institutions (Shorter 1997).

Nevertheless, it would be the bromides that were most widely used in the second half of the 19th century, either as sedatives or for the treatment of epilepsy, having been introduced for these applications by the internist and obstetrician Sir Charles Locock in 1857. It was in that year that Locock reported his results in the treatment with bromides in women with what the author has named as catamenial or hysteriform epileptic seizures, obtaining positive outcomes in 14 women out of a sample of 15. From that time on, bromides were widely introduced in asylums and similar institutions throughout Europe, given their sedative and antiepileptic properties, the relevant function in the latter case being to reduce the expression of the epileptic patients' sexuality. Another contribution in relation to the neuropsychiatric use of bromides was made by the British doctor Neil MacLeod, who in 1897, while working in Shanghai, carried out the first "sleep cure" with these salts. MacLeod called it "the bromide sleep" (MacLeod 1900), and some authors, such as Shorter (1997), have considered this technique as the first pharmacological therapy that, within psychiatry, succeeded in improving the symptoms of psychiatric patients. However, the main problem with bromides resided in their high toxicity (neurological and gastrointestinal disorders, irritability, hallucinations, deliria, and lethargy), given their long half-life (elimination taking around 12 days) and their capacity for accumulation in tissue; as a result, they were gradually phased out after the introduction of barbiturates in the early part of the 20th century (Balme 1976).

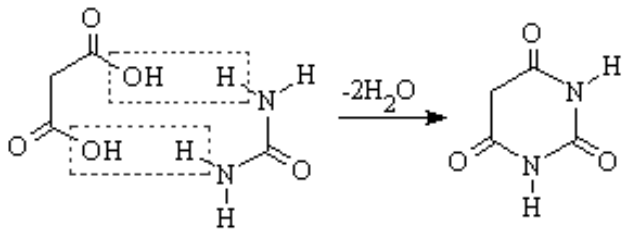


Figure 1 Synthesis of barbituric acid, from the combination of malonic acid (left) and urea (right).

Other substances used as hypnotics and sedatives and eventually as anticonvulsants were also introduced in the 19th century and the early decades of the 20th century. Such is the case of paraldehyde, discovered by Wildenbusch in 1829 and introduced into clinical practice by Vincenzo Cervello in 1882; and sulphonal, whose hypnotic action was discovered by chance by Eugen Baumann and Alfred Kast in 1887 (Kast 1888). Finally, those seeking to treat epilepsy turned, as well as to potassium bromide, chloral hydrate, or hyoscine, to a whole host of substances of more questionable efficacy, including opium, belladonna, atropine, stramonium, strophanthus, *cannabis indica*, and zinc oxide.

The discovery and clinical introduction of barbiturates as sedative and hypnotic agents

Between the 1920s and the mid-1950s, practically the only drugs used as sedatives and hypnotics were barbiturates (Lehmann and Ban 1970). From a chemical point of view, these drugs are closed-chain ureic compounds, whose nucleus is malonylurea (a combination of urea, a product present in animal excrement, and malonic acid, an acid derivative taken from apples) (Figure 1). Barbiturates were synthesized in 1864 by Adolf von Baeyer, though the synthetic process was developed and perfected by the French chemist Edouard Grimaux in 1879, making possible the subsequent widespread development of barbiturate derivatives (Carter 1951). Von Baeyer, a disciple of Robert W Bunsen and Friedrich A Kekulé, taught at the universities of Strasbourg and Munich, was the founder of what was to become the Bayer Chemical Co, and received the Nobel Prize in Chemistry in 1905 for his contribution to the development of organic chemistry (Figure 2a).

There are various hypotheses about the origin of the term "barbiturates" (Dundee and McIlroy 1982). According to one of these, Baeyer may have used this name for the compounds for sentimental reasons, in honor of his friend Barbara (Cohen 1943). Other authors, however, claim that the name derives from the fact that Baeyer celebrated his discovery in a tavern near his home that was frequented by artillery officers, who themselves were celebrating the day of their patron, St Barbara (Sharpless 1970). A third possibility is that the term is inspired by the "barbed" appearance of the crystals of these ureic compounds (Fieser 1944). In any case, it is clear that the union of the elements "barb(ara)" and "urea" forms the basis of the name.

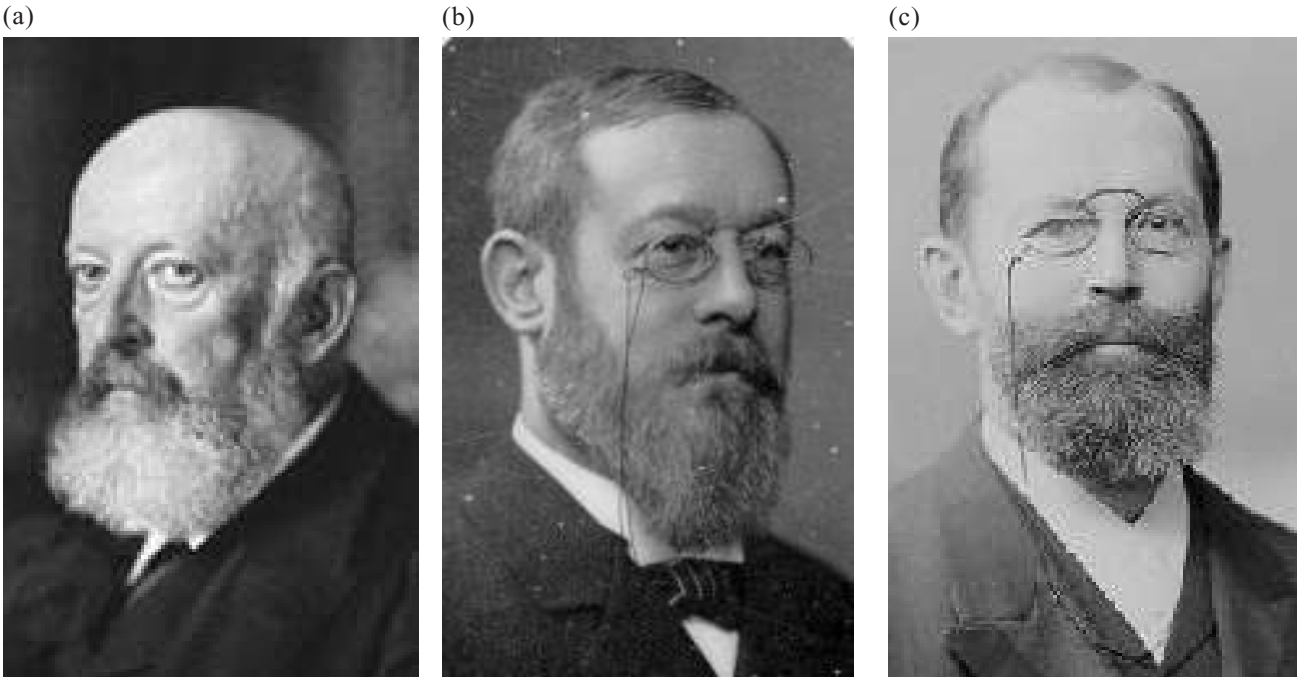


Figure 2 (a) Adolf von Baeyer (1835–1917); (b) Josef von Mering (1849–1908); (c) Emil Fischer (1852–1919).

From malonylurea to barbital

The first of the barbiturates to come onto the market was diethyl-barbituric acid, also known as barbital, malonal, or gardenal. Synthesized in 1881 by Conrad and Guthzeit, on treating the argentic salt of barbituric acid with ethyl iodide, it was introduced clinically as a hypnotic by the German companies E Merck (Darmstadt) and F Bayer and Co (Elberfeld) in 1904, thanks to the work of Josef Freiherr von Mering (Figure 2b) and Emil Fischer (Nobel Prize in Chemistry, 1902) (Figure 2c).

Von Mering, who taught pharmacology at the University of Halle, had observed that some of the synthetic compounds obtained towards the end of the 19th century and commercialized as hypnotics, such as sulphonal, contained in their molecular structure a carbon atom with two ethyl groups. Furthermore, knowing of von Baeyer's work with derivatives of urea, von Mering decided to study the hypnotic properties of diethyl-acetylurea, and found that it was even more potent than sulphonal. The next step was to analyze the properties of 5,5-diethyl-barbituric acid, for which he turned to Fischer, an old friend from his student days. At that time, Fischer, doyen of the German organic chemists, was Professor of Chemistry at the University of Berlin. Moreover, Fischer was well acquainted with the chemistry of malonylurea, as he had been von Baeyer's assistant in Munich for eight years. Together with his nephew Alfred Dilthey, he tested the new, resynthesized product, demonstrating, in dogs, that its hypnotic power was far greater than that of von Mering's diethyl-acetylurea (Sneader 1985). When Fischer told his friend von Mering about this finding, the latter happened to be in the Italian city of Verona, and it was this that prompted him to call the new drug Veronal® (Cohen 1943; Sharpless 1970). Nevertheless, other authors argue that the name Veronal (from Latin, verus = true) was coined by Fischer, who claimed to have found the "true" hypnotic compound (Sneader 1985). This new hypnotic drug was patented by Fischer in January 1903, and two months later the first scientific data on barbiturates were published in a brief report (Fischer and von Mering 1903). The licence for its commercialization in the USA was granted to the Winthrop Chemical Company.

The term barbital for diethyl-barbituric acid is a later development, coming as a result of the economic effects of World War I. After the United States entered the conflict, in 1917, Congress passed the Trading with the Enemy Act 1917, which permitted them as a kind of war booty to manufacture German products protected by patent, modifying their generic name and with the profits going to the American subsidiaries of the German companies (Sneader 1985). Thus, the American Medical Association approved the name barbital, whilst in the United Kingdom, through a similar mechanism, diethyl-barbituric acid came to be called barbitone. From this point on the two endings "-al" and "-one" could be found in the nomenclature of barbiturates.

Veronal had hypnotic, sedative, and anticonvulsant properties (Figure 3a). It could calm manic patients and help melancholic patients to sleep, and was an effective inducer of sleep in insomniacs. The first trials with barbital were carried out by Hermann von Husen (1904), a young psychiatrist affected by sleep disorders, who tried the new drug on himself. After taking 0.5 g of Veronal the first night and 1 g the following night, he reports:

> In both cases, after 10–15 minutes, I fell into a growing state of dejection that led to deep sleep after around 30 minutes. After half a gram of Veronal I slept for 8 hours, and after a whole gram, around 9 hours. On the first morning I awoke fresh and rested; on the second morning, after the higher dose, I found it difficult to get out of bed (von Husen 1904, p 59).

The consolidation of barbiturate therapy: phenobarbital

By means of small modifications to the chemical structure of the barbituric acid molecule, more than 2500 different agents were synthesized. The first barbital analogs, numbering around 18, were synthesized and tested by the group made up of von Mering, Fischer, and Dilthey. One of them, perhaps that most widely used subsequently, was phenobarbital, synthesized by Hörlein in 1911, on substituting one of the ethyl groups by a phenyl radical. Phenobarbital was employed in therapy as a hypnotic for the first time in 1912 by Loewe, Juliusburger, and Impens, and that same year it was commercialized by F Bayer and Co, under the name Luminal®. Phenobarbital, with a more prolonged pharmacological action than its predecessor, soon became "king of the barbiturates", both in hospitals and in outpatient care (Shorter 1997). This drug opened up the way, moreover, to another important therapeutic application of barbiturates, as will be mentioned later: the treatment of epilepsy.

Both Veronal (barbital) and Luminal (phenobarbital), the first two representatives of the series of barbiturates, were accepted by the international pharmacopoeia, such as the *United States Pharmacopoeia* (USP X) in 1926, and the *British Pharmacopoeia* in 1914 and 1932, respectively.

Later, both drugs were also included in the *Pharmacopoeia Internationalis*.

Clinical introduction of the new barbiturates

The new barbiturates brought substantial advantages compared with their classical predecessors, such as a greater potency and duration of action, as well as a wider therapeutic range. However, of the several thousand that were synthesized, only about 50 came onto the market, and of these no more than a couple of dozen were regularly used in clinical practice. The next barbiturate to be used successfully in therapy was butobarbital, whose history begins in World War I. The British war effort required large quantities of acetone for the manufacture of explosives (Sneader 1985), and one of the solutions was provided by Chaim Weizmann, who would later become the first president of the state of Israel. Weizmann found that the bacteria *Clostridium acetobutylicum* was capable of transforming materials rich in starch into acetone and butyric alcohol, and at low industrial cost. After the war, the cost of butyric alcohol, a chemical that was as useful as it was expensive, fell drastically, thus permitting its use for obtaining numerous synthetic drugs. In 1920, Roger Adams (Abbott Laboratories, Chicago, USA) synthesized the ester of 5-butyl-5-ethyl-malonic acid, an intermediate stage in the synthesis of a butyl analog of barbital, which was finally synthesized by Arthur Dox (Parke Davis and Company, Detroit, USA) in 1922, and marketed the following year by Abbott Laboratories, under the name Neonal® (Sneader 1985). Butobarbital (butethal in the USA) was three times as strong as barbital and its period of action was much shorter due to its lipophilicity, which greatly lowered the possibility of "rebound" drowsiness the day after administration.

In the years that followed, new barbiturates continued to come onto the market. In 1923, it was amobarbital (Amytal®), synthesized by Shonle and Moment (Eli Lilly Company, Indianapolis, USA) by adding a carbon atom to the butyl chain of butobarbital; and in 1929, Horace A Shonle also synthesized secobarbital (Seconal®). Both barbiturates had quite similar pharmacological properties to those of butobarbital (Sneader 1985). The next drugs of this series to be introduced were pentobarbital (Nembutal®), synthesized by Volwiler and Tabern (Abbott Laboratories) in 1930, and thiopental (Pentothal®). The latter, a sulfur derivative of pentobarbital, presented at the American Chemical Society congress in San Francisco in August 1935 (Tabern and Volwiler 1935), would revolutionize intravenous

(a)



(b)



Figure 3 (a) Elixir Veronal from Dr Bustamante's Laboratories it is a "Practical treatment of insomnia". They have also added audaciously "Secure and harmless". Finally they say that "it tastes good and acts smoothly, being absorbed by the organism". (b) Advertisement for Abbott sodium pentobarbital in an American medical journal of 1933, highlighting its "short but powerful hypnotic effect and prolonged sedative action from small dosage".

Table 1 Mean and maximum dosage of the pharmacological agents used as hypnotics before the benzodiazepine era

Drug	Dosage per administration: Mean dosage	Dosage per administration: Maximum dosage	Daily maximum dosage
Ethchlorvynol	250 mg	500 mg	750 mg
Chloral hydrate	500 mg	1000 mg	1000 mg
Paraldehyde	3 mL	8 mL	8 mL
Glutethimide	250 mg	500 mg	500 mg
Methyprylon	200 mg	400 mg	400 mg
Methaqualone	200 mg	400 mg	600 mg
Phenobarbital	50–100 mg	200 mg	200 mg
Amobarbital	50–100 mg	200 mg	200 mg
Secobarbital	100 mg	200 mg	200 mg
Pentobarbital	100 mg	200 mg	200 mg
Sodium tripental	250 mg	500–1000 mg	–

NOTE: The doses indicated correspond only to the hypnotic use of these drugs. The maximum doses of the barbiturates are not considered when they are used as anticonvulsants.

anesthesia and would be the only representative of the thiobarbiturate family to be officially recognized, being accepted first by the *British Pharmacopoeia* (1942, 7th Add) and subsequently by the *United States Pharmacopoeia* (1947, USP XIII) and the *Pharmacopoeia Internationalis* (1951, Volume I). Figure 3b shows an advertisement for pentobarbital in an American journal of the time.

Table 1 shows the recommended dosages of barbiturates used as hypnotics together with those of other drugs also used as hypnotics prior to the clinical introduction of benzodiazepines at the end of the 1950s. Among these last agents, chemically different from barbiturates although with similar pharmacological actions, we have to mention glutethimide (USV Pharmaceutical Corporation, 1954), methyprylon (Hoffmann-La Roche, 1955), methaqualone (King George Medical College, Lucknow, India, 1956; William H Rorer Inc, 1965), chlormethiazole (Hoffmann-La Roche, 1956), and ethchlorvynol (Pfizer, 1956). Most of these drugs were introduced as barbiturate substitutes, due to the fact that they seemed to offer a wider margin of safety. However, the clinical experience has demonstrated that their addiction liability and the severity of withdrawal symptoms were similar to those of barbiturates, and most of them were removed from the market some years later.

The role of barbiturates in "sleep cures" for schizophrenic patients

The hypnotic properties of some barbiturates were rapidly applied to the treatment of psychotic patients, thanks to their induction of a state of deep and prolonged sleep. The pioneer of these techniques was the Italian psychiatrist Giuseppe Epifanio, working at the University Psychiatric Clinic in Turin, who described his technique in an article published in 1915. The lack of impact of this development on the international scientific community can be attributed to the fact that it was published only in an Italian journal, and in the middle of the Great War (Epifanio 1915). It was on 25th March 1913 that Epifanio administered the first dose of Luminal to a girl aged 19 (FL) affected by manic-depressive psychosis, extending the treatment over a period of 4 days. The patient fell into a "deep sleep" that lasted until 9th April, was discharged at the end of June, and was in remission during the next two years. This case marked the beginning of what Manfred Bleuler would describe in 1955 as "the first of the great physical therapies" for mental disorders (Windholz and Witherspoon 1993).

However, the clinical introduction of these techniques is historically associated with Jakob Klaesi, a psychiatrist at the University Psychiatric Clinic in Zurich (Psychiatrische Universitätsklinik, Burghölzli, Switzerland). His "sleep cures" ("Dauerschlaf", "Dauernarkose"), proposed in 1920 within the framework of the 59th Assembly of the Swiss Psychiatry Society (28th November 1920), enjoyed great prestige at the time and directly involved the use of barbiturates. Klaesi's initial proposal was that his techniques for inducing deep hypnosis, taken from Epifanio, would facilitate communication between patient and psychotherapist ("to achieve a better relationship between doctor and patient") (Shorter 1997, p 204). Klaesi introduced his method in Switzerland, and based it on pre-medication with morphine (0.01 mL) and scopolamine (0.001 mL) and the subsequent administration (intravenous or subcutaneous), over at least 6–7 days, of Somnifen® (Figure 4), a mixture of diethyl and dipropenyl-barbituric acid and diethylamine (2–4 mL), manufactured by the Hoffmann-LaRoche company. The percentage improvements reported by Klaesi, in samples of schizophrenic patients, ranged from 25% to 33%, which is 10% higher than the rates of spontaneous remission in this type of patient (Klaesi 1922). These cures ("prolonged sleep therapy") acquired great popularity during the 1920s, with numerous variations as regards methodology and applications (agitated schizophrenic patients, delirium tremens, autism, morphine dehabituation, etc), though the administration of Somnifen was always involved (Windholz and Witherspoon 1993). Nevertheless, it is important to consider a fact mentioned in the first publication on the effectiveness of the method in schizophrenic patients: three of the 26 patients recruited died during the study due to



Figure 4 The packaging of Somnifen®, produced by Hoffmann-LaRoche.

bronchopneumonia or hemorrhages in the cardiac muscles (Klaesi 1922). A few years later, some authors set the mortality rate with Somnifen at around 5% (Müller 1927).

The legacy of Somnifen was taken up at the same Swiss clinic in Burghölzli by pharmacologist Max Cloetta and psychiatrist Hans W Maier, who sought a compound that would be better tolerated. In 1934, they prepared a compound based on paraldehyde, amylen hydrate, chloral hydrate, alcohol, ephedrine hydrate, digalen, and isopropyl-allyl-barbituric acid, which they called Cloettal® or "Cloetta Mixture", and which was rectally administered (Cloetta and Meier 1934). This preparation was widely used in schizophrenic patients, not only in the Zurich clinic (Boss, Monnier), but also elsewhere, such as in the Soviet Union by Ivan P Pavlov (Windholz and Witherspoon 1993). The most rigorous study with this mixture was carried out in Burghölzli by Marcel Monnier, who, with a sample of 125 schizophrenic patients, applied strict exclusion criteria (elderly patients and those with renal or respiratory disorders) before applying the preparation. Only 84 patients were given the Cloetta Mixture, and 53 of them improved (40 were even discharged from the hospital). Nevertheless, two patients died during the treatment as a result of respiratory complications associated with the medication (Monnier 1936).

Eliot Slater, of the Maudsley Hospital in London, recalled that "sleep cures" were "the only treatment we had back in the 1930s that was of any value in acute psychotic disorders" (Slater 1975, p 74). After this initial period, the use of "sleep cures" based on barbiturates began to decline due in part to problems of safety, as well as to the clinical introduction of new biological therapies for the treatment of schizophrenic patients such as Sakel's (1935) insulin shocks or the cardiazolic shocks of von Meduna (1937). Even so, as Shorter (1997) points out, "the story of barbituric narcosis has a corollary". This refers to the work of D Ewen Cameron in the mid-1950s at the Psychiatry Department of the Allan Memorial Institute in Montreal (Canada). Financed by the Central Intelligence Agency (CIA), Cameron developed his technique of "psychic driving" (Cameron 1956), a prototype version of what would come to be known commonly as "brainwashing". With this technique, in which barbiturates were also used, Cameron intended to take advantage of prolonged sleep to force his patients to listen to propaganda messages, which, in this case, were designed to quicken their recovery. In spite of its aims, eminently clinical, this work was widely criticized in the mass media at the time.

Barbiturates as antiepileptic agents

With phenobarbital, in addition to confirmation of the excellent hypnotic effect of barbiturates, it was demonstrated that these drugs had significant anticonvulsant properties. The discovery of these properties took place in 1912, the year of their commercialization, and provided another example of serendipity in the field of psychopharmacology. Alfred Hauptmann, resident psychiatrist in Freiburg, was given responsibility for the care of epileptic inpatients. Finding it impossible to sleep properly because of the continual convulsive seizures of his patients, Hauptmann decided to administer them some of the new hypnotics on the market, among them phenobarbital. Surprisingly, Hauptmann observed that the incidence of seizures in patients treated with low doses of phenobarbital fell notably, not only during the night, but also during the day (Hauptmann 1912). One of Hauptmann's most important conclusions was that phenobarbital not only reduced the number of seizures, but also their intensity, allowing many patients to leave the institutions and enjoy a normal working life.

It was in this way that the anticonvulsant properties of barbiturates were discovered, phenobarbital being the first truly effective drug for the treatment of epilepsy (Iváñez and Díez-Tejedor 1998). Table 2 shows, by way of example,

Table 2 Anticonvulsant drugs used at the National Hospital (Queen Square) in London, before and after the clinical introduction of phenobarbital in the treatment of epilepsy

1910		1930	
Drugs of definite benefit	**Drugs of doubtful benefit**	**Drugs of definite benefit**	**Drugs of doubtful benefit**
Bromides	Monobromate of camphor	Bromides	Zinc salts
Chloral hydrate	Eosinate of sodium	Bromide combinations	Iron
Glycerophosphates	Chloretone	**Phenobarbital**	Digitalis
Borax	Antipyrin	Borax	Strophanthus
Belladonna		Double tartrate of	Calcium
Zinc salts		borax and potassium	Opiates
Opium		Belladonna	Hypnotics
Strychnine		Nitroglycerine	
Chloride of calcium			
Atropine			

Adapted from Shorvon and Sander (1996).

the anticonvulsant agents commonly employed in the treatment of epilepsy before and after the introduction of phenobarbital.

However, the international acceptence of phenobarbital as an antiepileptic drug was seriously delayed, due first of all to the scarce significance outside Germany of the journal in which Hauptmann published the reports of his work (*Münchener Medizinische Wochenschrift*), and secondly, to the outbreak of World War I. Indeed, phenobarbitone was not commercialized in Great Britain until 1923, by the Winthrop Chemical Company. In one of his first reports on the use of phenobarbitone in England, Charles Brooks, Colony Medical Officer at the Chalfont Centre in London, noted its particular efficacy in severe cases of convulsions and in epileptic conditions with associated mental deficiency. Brooks also mentioned that if the barbiturate did not show a certain degree of effectiveness in the first months of treatment, the result of the therapy would not be satisfactory, so that it would be necessary to find an alternative (Brooks 1922). In a later report, Brooks made a close examination of patterns of use of phenobarbitone, concluding that it was more effective than bromides, but that it was not particularly useful in patients with low-intensity seizures (Brooks 1923).

It was precisely the Chalfont Centre that published, at the end of the 1920s, one of the first therapeutic guides for newly admitted epileptic patients, written by F Haward (Shorvon and Sander 1996). According to this guide, potassium bromide was the first-choice treatment, though it should be substituted by phenobarbital if there was no remission in the seizures within a given period of time (Table 2). If after three months of treatment the improvement was not clear, the guide recommended treatment with a combination of Luminal® and potassium bromide. Moreover, it set down the recommended dosage for phenobarbitone: 1 grain (65 grams) in the morning and another at night for adult patients, and 1/2 grain in the case of children; the dose was to be increased gradually, according to the clinical response, but should never exceed 6 grains per day (Haward 1928). At the beginning of the 1930s, the use of phenobarbital superseded definitively that of bromides in the treatment of epileptic seizures, despite the first reports of pharmacological tolerance and the risk of seizures when withdrawal was too abrupt. Phenobarbital is currently the most widely-prescribed antiepileptic drug in the world (Shorvon 2000), even though in the developed countries it has passed onto a secondary plane in therapy, for the treatment of partial and generalized seizures, due to its profile of adverse effects.

In the years following the discovery of the antiepileptic properties of phenobarbital, there were studies of numerous barbiturate derivatives in the field of epilepsy, the most important being mephobarbital (Prominal®) (Weese 1932) and, above all, deoxybarbital or primidone (Mysoline®). Primidone was synthesized by Bogue and Carrington (Imperial Chemical Industries Ltd, ICI, Manchester, UK) in 1949, demonstrating its antiepileptic activity in patients with generalized seizures in 1952 (Handley and Stewart 1952). Initially, primidone awoke great therapeutic interest, as it was thought that its anticonvulsant effectiveness may be greater than that of other available barbiturates, and without sedative effects (Bogue and Carrington 1953), but this interest soon waned after it was demonstrated that phenobarbital was a metabolite of this drug, together with phenyl-ethyl-malonamide (Butler and Waddell 1956). Comparative clinical studies carried out with phenobarbital and its prodrug, primidone, showed no differences between

the two (Oleson and Dam 1967). Currently, primidone is still considered as being of some use in partial and secondary generalized seizures, but is not a first-choice drug. Unlike phenobarbital, it cannot be used in epileptic status, since no galenic formulation has been developed for its parenteral administration.

The discovery by Houston Merritt and Tracy Putnam (Boston City Hospital, USA) in 1938 of the anticonvulsant properties of phenytoin (the first drug to show that an antiepileptic need not be a hypnotic), in 1944 of trimethadione, and in the late 1950s of carbamazepine, extended the spectrum of antiepileptic drugs, resulting in decreased use of barbiturates in these applications.



Figure 5 The packaging of Abbott Pentothal® at the time of its clinical introduction in the late 1930s. Pieces from the Museum of the Buenos Aires Anaesthesiology Association (Argentina).

The use of barbiturates in intravenous anesthesia

Despite the existence of some publications on the use of Somnifen® as a general anesthetic as early as 1921 by the French anesthetist Daniel Bardet – who noted that his patients woke up very slowly and with serious headaches (Bardet 1921) – the first barbiturate to be used systematically in anesthesia was sodium sec-butyl-(2-bromo-allyl)-barbiturate (Pernocton®). This was introduced into the field by the German obstetrician Bumm in 1927 (Bumm 1927). Subsequently, as new barbiturates were synthesized for their oral administration as sedatives, sodium salts of the same drugs were formulated, which could be administered intravenously and used as anesthetics (Dundee and McIlroy 1982). Notable among the pioneers in this field is John S Lundy of the Mayo Clinic (Rochester, USA), who introduced sodium amobarbital (1929) and sodium pentobarbital (1930) in anesthesia.

The addition of a methyl group to the butobarbital molecule, by the chemists Kropp and Taub at Bayer (IG Farbenindustrie, Leverkusen) in the early 1930s, gave rise to hexobarbital, whose sodium salt (Evipal®), introduced into clinical anesthesia in 1932 (Weese and Scharpff 1932), constituted the first barbiturate agent that induced anesthesia. Ten years after its introduction, more than 10 million people had undergone operations with the help of this drug (Adams 1944). The duration of hexobarbital's action was shorter than that of its predecessors, given its greater lipophilicity, but under its effect some muscular movements occurred. This problem was solved through the next modification of the chemical structure of the basic nucleus of the barbiturates, the addition of a sulfur group to pentobarbital. Thus born were the agents that would revolutionize intravenous anesthesia, the thiobarbiturates, thanks to the work of Volwiler and Tabern of Abbott Laboratories (Tabern and Volwiler 1935). These agents were studied as anesthetics at the Mayo Foundation (Rochester) by John Lundy's group, who gave the sulfur derivative of pentobarbital the name Thionembutal®. Its sodium salt was marketed as Pentothal (Figure 5). The team led by Ralph M Waters at the University of Wisconsin Medical School (Madison, USA) were the first to begin clinical administration of Pentothal, and published their results in 1936 (Pratt et al 1936). This agent rapidly displaced the rest of the barbiturates as an anesthetic, partly due to the swiftness of its onset and its short action period, and it currently remains the preferred intravenous anesthetic in many types of surgical intervention. Despite the anesthetic efficacy of both hexobarbital and thiopental, the barbiturates most commonly employed in surgery in the mid-20th century, they were not without their clinical problems. Such problems were brought to the public eye in particularly unfortunate fashion after the involvement of these agents, apparently due to malpractice, in numerous cases of death in patients treated in states of shock after the Japanese attack on Pearl Harbor in December 1941. Some authors went as far as describing these drugs as providing the "ideal form of euthanasia" (Halford 1943).

After World War II the search for anesthetic barbiturates continued, and new compounds such as thiobutobarbital (Horatz and Stürtzbecher 1952) were introduced, though the only one that truly challenged thiopental was methohexital (Brietal®), developed by SM Chernish's group at Lilly Research Laboratories (Indianapolis, USA) in 1956. In clinical trials, methohexital showed itself to be more potent than thiopental and to lead to quicker recovery in patients; it was recommended for use as an anesthetic

inducer in minor outpatient surgery (Taylor and Stoelting 1960). The subsequent development of other anesthetic agents for intravenous administration (hydroxydione, alphaxalone, etomidate, propofol, etc) led to a reduction in the use of barbiturates in this context.

The peak and decline of barbiturate therapy

As mentioned earlier, chemists from different universities and pharmaceutical companies managed to synthesize over 2500 barbiturate derivates. The differential pharmacokinetic properties of these agents made it possible to draw up a practical clinical classification, based on the duration of their pharmacological action (Hollister 1983). Thus, the barbiturates in the category of short or intermediate action (secobarbital, amobarbital, pentobarbital) were employed initially as hypnotics, whilst those of prolonged action (phenobarbital) were widely used as anxiolytics and anticonvulsants; ultrashort-acting agents, notably sodium thiopental, were especially useful as anesthetic inducers for minor operations (Table 3). From time to time, some barbiturates have been used in the treatment of other disorders. One such case is the use of primidone in the management of essential tremor (Koller et al 2000), while another is that of combinations of barbiturates and analgesics (salicylates, codeine, etc) in the treatment of headaches, migraines, and other types of pain (Wolf et al 1941), though such applications are considered counterproductive today.

Some barbiturates, such as sodium amytal and sodium pentothal (the latter being known as "the truth serum") were widely known and used as coadjuvant agents for the exercise of narcoanalysis, as initially developed by Bleckwenn in 1930 (Bleckwenn 1930a, 1930b). In principle, the application of an infusion of barbiturates reverted temporarily the catatonic state of certain schizophrenic patients. These cures for catatonia allowed patients, for a few hours, to maintain conversations and interact with their environment, before returning to their state of lethargy. Despite the fact that the response was somewhat brief, these cures were quite customary in European asylums in the 1930s and 1940s. But a variety of this technique became widespread during and after World War II: it consisted of the intravenous administration of a short-acting barbiturate, which had a disinhibiting effect (potentiating positive transfers) and facilitated the subsequent exercise of psychotherapy (a phenomenon referred to as "cathartic abreaction") (Lehmann 1993). This technique was also called by other authors the "induced crepuscular method".

It was during the 1930s and 1940s that barbiturates attained their greatest popularity and were most widely used, putting them in a position that could be compared, according to Hollister (1983), to that currently held by benzodiazepines. The barbiturates most commonly used at that time were phenobarbital, sodium amobarbital, sodium secobarbital, sodium pentobarbital, and sodium thiopental. Despite their widespread use during the first half of the 20th century, no barbiturate succeeded in eliminating the main drawbacks of these drugs, which were the phenomena of dependence and death by overdose (Johns 1977). Among the paradoxes of destiny is the possible death through overdose of the two scientists who introduced the first barbiturate, Fischer and von Mering, after some years of dependence upon these substances (Escohotado 1996). To reduce these problems, from a legal perspective, a series of laws were passed aimed at regulating the distribution and sale of barbiturates. The first of these came into force in California in 1929. However, its effects were limited, if we consider, for example, that the production of barbiturates in the USA increased by more than 400% from 1933, with some 70 tons of these drugs sold in 1936. The problem continued during the following decade, and it became necessary to arrange special conferences for all those involved, such as that held in Washington, under the auspices of the American Pharmaceutical Association, on 12th October 1945 (*Conference on the Regulation of Use and Distribution of Barbiturates*). Barbiturate use in the pre-benzodiazepine period was such that, in the USA alone, production of these drugs reached, in 1955, the quantity

Table 3 Classification and principal clinical applications of the barbiturates most commonly employed before World War II

	Barbiturates	Trade name	Chemical name	Clinical indications
Long-acting	Phenobarbital	Luminal	5-ethyl-5-phenylbarbituric acid	Sedative
Intermediate-acting	Amobarbital	Amytal	5-ethyl-5-isopentylbarbituric acid	Hypnotic
Short-acting	Pentobarbital	Nembutal	5-ethyl-5-(1-methylbutyl)-barbituric acid	Hypnotic and anticonvulsant
	Secobarbital	Seconal	5-allyl-5-(1-methylbutyl)-barbituric acid	Hypnotic
Ultrashort-acting	Thiopental	Pentothal	5-ethyl-5-(1-methylbutyl)-thiobarbituric acid	Anesthesia inducer

Adapted from Hollister (1983).

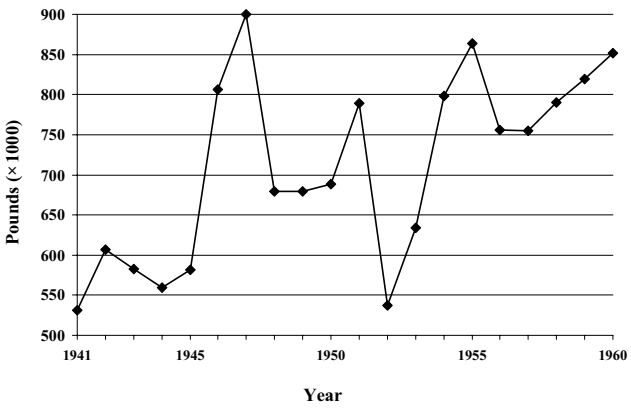


Figure 6 Evolution of annual barbiturates production in USA for the period 1941–1960. Adapted from Fort (1964).

necessary for the treatment of 10 million people throughout an entire year. Figure 6 shows the industrial production of barbiturates and their derivatives in the USA during the 1940s and 1950s.

The capacity of barbiturates to cause dependence was described in the medical literature as early as one year after the commercialization of barbital ("the Veronal habit"), though reliable evidence of the potential of these drugs to generate abuse was not available until the 1950s (Glatt 1962). In fact, doses 4–6 times higher than the therapeutic dose as hypnotics of the short-acting barbiturates (400–600 mg/day of amobarbital, secobarbital, or pentobarbital) brought about, if the treatment was sufficiently prolonged, authentic withdrawal syndromes when use was stopped. In order to palliate these effects, the Narcotics Expert Committee at the World Health Organization recommended (at their sessions of 7th–12th January, 1952, and 18th–24th October, 1956) that barbiturates should only be available on medical prescription. In spite of this, and according to different estimates, in 1965 there were 135 000 barbiturate addicts in England, whilst in the United States it was declared, by a special drug-dependence committee set up by President Kennedy in 1962, that there may be as many as 250 000 Americans addicted to barbiturates. Indeed, the USA currently produces 30 barbiturate pills per inhabitant per year (Escohotado 1996). Some barbiturates (amobarbital and pentobarbital) have even found their way into mixtures with amphetamine derivatives (*goofballs*), such as Dexamyl®, a combination of dextroamphetamine and amobarbital.

In relation to the frequent cases of death by overdose, given the small therapeutic margin of these substances, it should be pointed out that this was a common method in suicide attempts. It suffices to recall, in this regard, the famous case of Marilyn Monroe, on whose death certificate it clearly states "acute poisoning by overdose of barbiturates" (Figure 7). The lethal effect of these compounds was such that a mixture of barbiturates with other substances

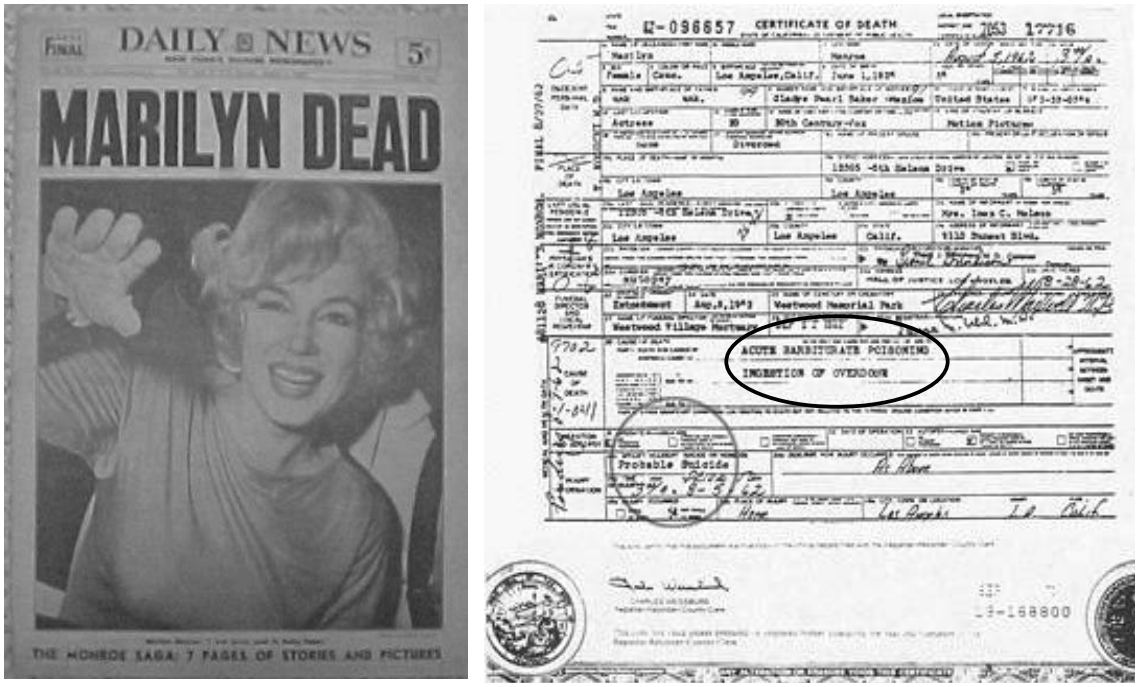


Figure 7 Death certificate of the actress Marilyn Monroe, issued on 28th August 1962. The circles indicate cause of death ("Acute barbiturate poisoning. Ingestion of overdose") and the intentionality ("Probable suicide").

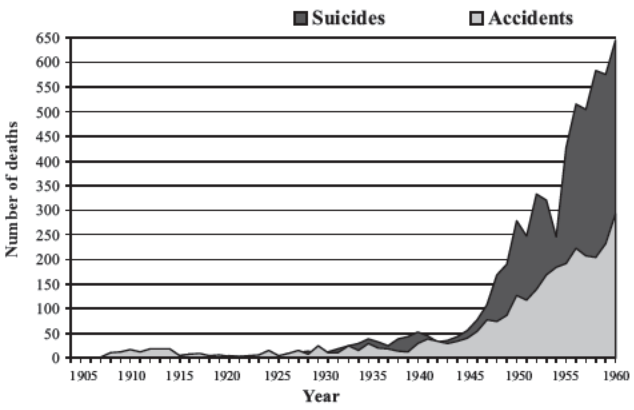


Figure 8 Deaths from overdose of barbiturates in England and Wales during the period 1905–1960 (Registrar-General's Statistical Review for England and Wales). Includes both accidental deaths and suicides. Adapted from Glatt (1962).

was even employed in some USA states for the execution of prisoners sentenced to death. Furthermore, there are classic reports of fatal overdose due to the "automatism phenomenon", whereby the patient would take his or her dose, only to forget that he or she had already taken it, given the amnesic effect of the drug, and take it again, this process being repeated several times (Richards 1934). Figure 8 shows the evolution of number of deaths (accidental or suicide) by barbiturate overdose in England and Wales for the period 1905–1960. In this regard, and in the city of New York alone, in the period 1957–1963, there were 8469 cases of barbiturate overdose, with 1165 deaths (Sharpless 1970), whilst in the United Kingdom, between 1965 and 1970, there were 12 354 deaths attributed directly to barbiturates (Barraclough 1974). These data should not surprise us, since in a period of just one year (1968), 24.7 million prescriptions for barbiturates were issued in the United Kingdom (Plant 1981). In view of these data, the Advisory Council Campaign in Britain took measures restricting the prescription of these drugs. Meanwhile, the prescription of prolonged-acting sedative barbiturates was strongly opposed through citizens' action campaigns such as CURB (Campaign on the Use and Restrictions of Barbiturates), especially active during the 1970s.

Furthermore, during the 1950s, when the use of barbiturates was at its peak, there took place a veritable revolution in the approach to psychiatric disorders, thanks to the introduction into clinical practice of the first pharmacological tools aimed specifically at treating these patients (Caldwell 1970; Jacobsen 1986; Ayd 1991; Lehmann 1993; Frankenburg 1994; López-Muñoz et al 2000; Ban 2001; Healy 2002). This "psychopharmacological revolution" began with the discovery and clinical use, from 1952, of chlorpromazine (López-Muñoz et al 2004), culminating in the commercialization of the first benzodiazepine, chlordiazepoxide, in 1960. The discovery of benzodiazepines was actually made possible, in part, by the 60 years of clinical and basic research provided by barbiturates, whose therapeutic life, from that time on, began to decline.

Barbiturates today

Currently, the use of barbiturates is circumscribed to quite specific therapeutic applications (Charney et al 2001). Thus, phenobarbital and butabarbital are still used as sedatives in cases of gastrointestinal and asthmatic functional disorders, as well as to antagonize the adverse central stimulant effects of some drugs, such as ephedrine, dextroamphetamine, or theophylline. Phenobarbital is also used in cases of withdrawal syndromes of hypnosedative agents. In the field of neurology, barbiturates (phenobarbital and primidone) are still employed, not only in the treatment of certain types of epilepsy (partial and tonic-clonic generalized seizures), but also in the emergency treatment of some types of convulsions, such as those associated with tetanus, eclampsia, cerebral hemorrhage, status epilepticus, or different forms of poisoning. As intravenous anesthetic inducers, ultrashort-acting barbiturates are of use, mainly thiopental and methohexital, the latter also being administered rectally in children or as a sedative in some diagnostic imaging explorations. Table 4 shows the therapeutic applications of barbiturates that have survived to the present day.

In addition to these approved indications, the barbiturates present other current uses. Phenobarbital is capable of improving the hepatic transport of bilirubin in patients with hemolytic jaundice, so that it can be used in newborn babies to treat hyperbilirubinemia and kernicterus. At a diagnostic level, amobarbital, in low doses, can be injected directly into the carotid artery prior to neurosurgery to identify the dominant cerebral hemisphere. Finally, anesthetic doses of barbiturates can attenuate post-surgical cerebral edemas and have positive effects in cases of cardiac and cerebral ischemia, reducing the size of the infarcted region. Moreover, barbiturates have been used since the 1970s in the management of acute traumatic brain injury in their capacity to reduce intracranial pressure (Marshall et al 1979). The mechanism through which high-dose barbiturates appear to exert their intracranial pressure-lowering effects is double: reduction of metabolism (with the consequent lower oxygen demand by cerebral tissue)

Table 4 Barbiturates currently employed and therapeutic applications

Barbiturate	Routes of administration	Therapeutic uses
Amobarbital	Oral, IM, IV	Insomnia Preoperative sedation Emergency management of seizures
Aprobarbital	Oral	Insomnia
Butabarbital	Oral	Insomnia Preoperative sedation
Mephobarbital	Oral	Epilepsy Daytime sedation
Methohexital	IV	Induction/maintenance of anesthesia
Pentobarbital	Oral, rectal, IM, IV	Insomnia Preoperative sedation Emergency management of seizures
Phenobarbital	Oral, IM, IV	Epilepsy Status epilepticus Daytime sedation
Primidone	Oral	Epilepsy
Secobarbital	Oral, rectal, IM, IV	Insomnia Preoperative sedation Emergency management of seizures
Thiopental	Rectal, IV	Induction/maintenance of anesthesia Preoperative sedation Emergency management of seizures

Adapted from Charney et al (2001).
Abbreviations: IM, intramuscular; IV, intravenous.

and modifications in vascular tone (Kassell et al 1980). Additionally some direct neuroprotective effects, such as membrane stabilization or inhibition of free radical-mediated lipid peroxidation, have been postulated (Piatt and Schiff 1984). Despite results of the multicenter randomized clinical trial published by Eisenberg et al (1988) that demonstrated the efficacy of high-dose barbiturates in severely head-injured patients with intractable intracranial pressure elevations, recent collaborations, based in Cochrane methodology, concluded that there is no evidence of health improvement in this type of patient (Roberts 2000).

The barbiturates introduced clinically one century ago were the first pharmacological agents to have demonstrated – in an historical period that was therapeutically inhospitable – a real efficacy in different neuropsychiatric disorders. They were the first-line treatment as hypnotics and anticonvulsants during the first half of the 20th century. The clinical results obtained in the last years in other indications such as the treatment (acute or prophylactic) of traumatic brain injury, although contradictory, seems to confirm that, from the pharmacological perspective, the barbiturates continue furnishing certain novelties and that in their history the last page has not yet been written.

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EXHIBIT 5

Pentobarbital anesthesia in labor

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A routine method of balanced obstetric analgesia and anesthesia which can be administered safely by the labor room nurses and the attending physicians is discussed. Eleven thousand eight hundred and twenty patients received intravenous pentobarbital. More than 2,000 of the author's patients received this type of anesthesia. The result of his last 1,000 consecutive anesthetics is discussed in detail. Maternal mortality and morbidity were zero. Corrected stillbirth and neonatal death rates were zero. Obstetric analgesia-anesthesia with the use of meperidine, propiomazine, and pentobarbital seems to be safe and is well accepted.

IN JANUARY, 1847, Sir James Young Simpson administered the first obstetric anesthesia. Ever since then scientists and physicians have worked to improve drugs and methods to make anesthesia better and safer.

Ideally, all obstetric anesthesia should be administered by an anesthesiologist trained in obstetric analgesia and anesthesia. However, only about 500 physicians enter approved anesthesia training programs every year. Shnider[11] found that 40 per cent of the physicians completing a training program in anesthesiology administered fewer than 50 anesthetic agents for vaginal delivery in 2 years, and most anesthesiologists do not order drugs for relief of pain during the first stage of labor.[7]

It has, therefore, been necessary to develop methods of analgesia and anesthesia which can be administered safely by the labor room nurse and the attending physician.

In 1951 Bertling and Burwell[2] published their results regarding pentobarbital anesthesia used routinely since 1948, and in 1953 Flowers[3] recommended balanced analgesia with the use of meperidine, scopolamine, and pentobarbital.

In our community hospital, pentobarbital was given the first time in December, 1951. Meperidine was given as premedication, and ether was used occasionally together with pentobarbital for the delivery. Later, tranquilizers were added, and the use of pentobarbital as the only anesthetic increased gradually, and within a few years it became the predominantly used anesthetic agent (Table I).

From Gaston Memorial Hospital.

Presented by invitation at the Twenty-ninth Annual Meeting of the South Atlantic Association of Obstetricians and Gynecologists, Hot Springs, Virginia, Feb. 5-8, 1967.

Analgesia

Certainly the results of anesthesias, analgesias, and tranquilizers cannot be separated, as all influence the condition of the mother and the newborn. In fact, I feel that it is the development of the new and efficient tranquilizers which have made the use of pentobarbital safer by increasing the analgesic effect of meperidine and the hypnotic effect of pentobarbital causing a smaller total dose of all drugs and, therefore, less risk of depression of the newborn infant. My material has been collected for a little more than 4 years. Promazine was used the first 5 months, propiomazine (Largon) since then (Table II).

The premedication with meperidine, 50 mg., and propiomazine, 40 mg., intravenously is now my preferred treatment. The patients receiving meperidine, 25 mg., and tranquilizers intramuscularly were patients suspected of being candidates for primary uterine inertia or patients in premature labor.

It is my impression that meperidine is

Table I. Number of patients receiving pentobarbital anesthesia

Year	*Total cases*	*Personal cases*	*Total deliveries*
1951	3	0	875
1952	Records not available		
1953	Records not available		
1954	38	1	1,300
1955	133	5	1,375
1956	288	40	1,489
1957	361	64	1,324
1958	674	41	1,345
1959	914	190	1,460
1960	1,206	220	1,457
1961	1,384	233	1,627
1962	1,375	231	1,536
1963	1,388	242	1,524
1964	1,340	229	1,588
1965	1,421	207	1,615
To 10/31/66	1,295	185	1,534
Total	11,820	1,888	20,049

Table II. Frequency of use and dosage of tranquilizers

No. of patients	*Drug and dosage*
507	meperidine 50 mg. propiomazine 40 mg. intravenously
299	meperidine 50 mg. propiomazine 20 mg. intravenously or intramuscularly
65	meperidine 50 mg. promazine 25 mg. intramuscularly
129	meperidine 25 mg. promazine or propiomazine intramuscularly

more depressing to the newborn than pentobarbital; therefore, only 62 patients received additional 25 or 50 mg. of meperidine for analgesia.

Pentobarbital sodium (Nembutal). This solution contains 50 mg. pentobarbital sodium per milliliter in a stable solution. It is strongly alkaline and can only be injected intravenously or deeply into a large muscle.

Pentobarbital is essentially a hypnotic drug, but it also produces a slight degree of analgesia. Following intravenous injection, pentobarbital rapidly produces cerebral depression of any desired degree. It is rapidly detoxified, chiefly in the liver. It transverses the placental barrier easily, and equilibrium between maternal and fetal circulation is reached within 3 minutes.

It has been said about the short-acting barbiturates, that they are "deadly easy to administer." However, if not more than 250 mg. of pentobarbital is given slowly intravenously, it is virtually impossible to oversedate the patient. Pentobarbital may, therefore, be given by a physician or nurse trained in intravenous injection and used to observe and supervise patients in labor.

Method

The patient is given meperidine 50 mg. and a tranquilizer intravenously when labor is established. As the effect of the premedication begins to wear off, the patient is given pentobarbital intravenously.

It is important to know that the dosage is determined by the clinical response of each patient. Approximately 100 mg. pentobarbital is first given slowly. The effect is observed for a couple of minutes before the remainder of the desired dose is given, bearing in mind that full effect is first obtained in 2 minutes. The dosage varies from 150 to 250 mg. depending upon the patient's reaction. Very often this will be sufficient to carry the patient through delivery with good amnesia with the use of pudendal block or local infiltration for the episiotomy site. However, in cases of slow labor, a second, usually smaller, injection of pentobarbital will be necessary. If it is given shortly before delivery, repair of the episiotomy is possible without a local anesthetic.

All the physicians on the staff now use pentobarbital anesthesia with minor differences in method. Variations are mainly found in the use of tranquilizers and in the timing of the pentobarbital injection. A few physicians give pentobarbital earlier than I do, while others give pentobarbital late in the second stage of labor.

In breech presentation, local infiltration of mepivacaine (Carbocaine) is used for the episiotomy, and pentobarbital is first given when the infant is delivered to the level of the umbilicus. At this time 3 to 5 c.c. of pentobarbital is given rather rapidly, and the in-

fant is delivered by partial breech extraction.

The level of anesthesia is usually satisfactory for common surgical procedures in obstetrics, such as low forceps delivery, forceps rotation, breech delivery, and version and extraction of a second twin.

When pentobarbital was first used in our department, it was often supplemented with ether for the delivery; however, as we gained experience, we found that the babies actually did much better when a larger amount of pentobarbital was given rather than when ether was given. Little by little, ether has, therefore, been virtually eliminated from our service. In my last 1,000 cases, ether anesthesia was used one time only for version and extraction of a second twin. This experience has been nicely confirmed by Phillips.[8]

Contraindications. Contraindications to pentobarbital are conditions with impaired liver function and conditions with depressed or obstructed respiration. We have found, as have others,[9] that pentobarbital can be given safely to patients with toxemia. Naturally, pentobarbital should not be administered to patients who are known to be sensitized to barbiturates.

All patients admitted with bleeding are very carefully screened and usually should not receive pentobarbital because of danger of shock and since the health and security of the mother and baby are possibly already jeopardized.

Severe prematurity is a contraindication because of the premature infant's lessened resistance to all analgesia and anesthesia.

Table III. General statistics regarding deliveries

1,000 patients	1,005 infants
378 primipara	622 multipara
807 spontaneous deliveries	145 low forceps
49 breech deliveries	3 version and extraction
1 cesarean section	785 episiotomies

Table IV. Dosage of pentobarbital given to patients

1,000 patients	305 mg.
378 primipara	338 mg.
622 multipara	284 mg.
488 patients	250 mg.
Maximum	650 mg.
Minimum	100 mg.

Material

I have delivered slightly more than 2,000 patients under pentobarbital anesthesia. The results of the last 1,000 pentobarbital anesthesia administrations given to my private white patients are shown in Tables III and IV.

Effect of pentobarbital on the mother

Maternal safety and results may be determined by evaluation of the following factors:

1. Blood pressure is usually not influenced by pentobarbital when given in moderate doses.

2. Respiration. Patients who are nervous and hyperventilating will often have a short period of apnea following the initial injection. However, respiration is always restored spontaneously in a couple of minutes, probably when the abnormally low CO_2 tension returns to normal.

Laryngeal spasm is a theoretical hazard of intravenous injection of the ultrashort-acting barbiturates; however, I have never seen it following an injection of pentobarbital, and it has, as far as I have been able to ascertain, never taken place in any of our 11,820 patients.

3. Local reaction. Pentobarbital sodium is a very alkaline solution and causes pain, tenderness, and infiltration when given subcutaneously; therefore, caution should be exercised during injection. Occasionally, a very mild, self-limiting, superficial phlebitis is seen in the cubital vein which is usually the preferred site of injection. I have, however, never seen any sloughing or any patient actually being incapacitated because of erroneous perivenous injection.

4. Amnesia is usually good from the moment pentobarbital is given, and I have, therefore, used scopolamine only very occasionally, nearly exclusively, in cases of pri-

mary uterine inertia before meperidine and pentobarbital were given.

5. Hyperactivity. When pentobarbital is given following premedication with meperidine and propiomazine, hyperactivity is fairly rare. The patients will be resting quietly between contractions with some groaning and moderately increased restlessness with the contractions. In 14 cases out of 1,000 it was noted in the chart that the patient was difficult to restrain.

6. Vomiting. All my maternity patients are instructed not to eat from the moment they are in labor. However, it cannot be avoided that some patients are admitted a few hours following a meal. Naturally, no general anesthetic causing anesthesia of this level should be given to a patient who has eaten recently. However, whether or not anesthesia is safe must be decided in each case depending upon the type and amount of food ingested. Pentobarbital, 250 mg., given intravenously, very slowly, will hardly be enough to suppress the coughing reflex if it is more than 2 hours since the patient was given meperidine and propiomazine, and the patient will be able to cough and, therefore, not aspirate.

In spite of close attention to this point, 3 of my patients vomited small to moderate amounts, while one vomited profusely. None had signs of aspiration, and all had an afebrile postpartum course.

This paper was from its beginning aimed at showing what can be accomplished with pentobarbital anesthesia as given by the attending nurse and obstetric staff; however, to get the full picture, it is here necessary to mention that one patient, admitted to our department by another physician, was given 250 mg. of pentobarbital by an anesthesiologist and vomited profusely, aspirated, was asphyxiated, and died from cardiac arrest.

7. Uterine contractions are not much influenced by pentobarbital. The total number of patients where it was felt that labor slowed down following pentobarbital was only 20 or 2 per cent. Conversely, it was felt that in many cases labor was shortened because the patient could not hold back following administration of pentobarbital. The patients are able to bear down well in the second stage as witnessed by the fact that only 145 patients were delivered by forceps while 807 delivered spontaneously (Table III).

8. Postpartum bleeding secondary to uterine relaxation is rare. All my patients are routinely given methylergonovine maleate (Methergine) 0.2 mg. I.V. following delivery. In only 19 patients, 1.9 per cent, was it found necessary to give additional medication. This low incidence also witnesses to the fact that the uterine contractions are not inhibited.

9. Recovery. Pentobarbital is a short-acting, but not ultrashort-acting barbiturate. It is metabolized fairly rapidly, and the patient will usually be awake in one to four hours after injection of our average dose. Naturally, it is necessary to observe them in the labor rooms during this time.

Effect of pentobarbital on the newborn

While it may be fairly easy to evaluate the effect of a drug on the parturients, it is very difficult to objectively evaluate the relation between the drugs given to the mother and the condition of the newborn because the numerous variable factors of pregnancy, labor, and delivery may affect the newborn. The following factors must be evaluated:

1. Stillbirth. In order for a drug to be safe, it must not be the cause of stillbirth. Of 1,005 infants, 9 were stillborn. Six fetuses died before labor and were born macerated. In one case, no fetal heart sound was heard on admission at 30 weeks' gestation following complete abruptio of the placenta. One fetus died during labor from congenital malformation before pentobarbital was given. One fetus, weighing 1 pound, 5 ounces, died during labor after the mother received 250 mg. of pentobarbital (Table V).

2. Neonatal death. Our drugs of choice

Table V. Stillbirth

Macerated fetuses	6
Died before injection of pentobarbital	2
Died following injection of pentobarbital, 1 pound, 5 ounces	1

Table VI. Causes of neonatal death

Anencephalic	1
Hydrocephalic	1
Congenital heart anomalies	1
Extreme immaturity	2
Multiple congenital anomalies of alimentary tract	1
Congenital defects in fat metabolism, died at 3 months old	1

Table VII. Possible connection between resuscitation and obstetric complications

Postmaturity	3
Prematurity	4
FHS irregular before pentobarbital	2
Placental dysfunction	6
Toxemia	4
Cord 3 times tight around neck	3
Prolonged second stage	9

Table VIII. Apgar score of 100 consecutive newborn infants

Apgar score	*Newborn infants*	*Infants resuscitated*
10	0	0
9	41	0
8	35	0
7	17	2
6	6	5
1	1	0

Table IX. Neonatal morbidity

	No.
Congenital heart anomalies	6
Sleepy in nursery	3
Hyaline membrane disease, 33 and 36 weeks	2
Episodes of cyanosis in nursery	3
Irritable, ruddy complexion	1
Grunty respiration, 38 weeks	1
Scattered atelectases, 37 weeks	1
Spastic paraplegia	1
Total	18

must not be the cause of neonatal death. Of 1,005 infants, 7 died neonatally, all from causes beyond our control (Table VI).

3. Resuscitation. The ease and speed with which the infants establish extrauterine respiration, circulation, and oxygenation is a good measure of their condition. All newborn infants are immediately aspirated with bulb syringe. If their color is not satisfactory within one or 2 minutes, in my or the attending nurse's opinion, an oxygen mask is held in front of their face. If they do not immediately respond to this, they will be resuscitated using intermittent positive pressure. Seventy-four babies received oxygen by mask for varying degrees of sluggishness and cyanosis, while 14 infants were resuscitated using intermittent positive pressure. This means that 8.8 per cent of the infants received oxygen in the delivery room; however, obstetric complications were found in 31 of these labor cases (Table VII).

Of the 88 infants resuscitated, 87 showed no evidence of permanent damage which could be related to labor, delivery, or anesthesia. However, one infant lived with evidence of permanent brain damage.

4. The Apgar score[1] has been generally accepted as an objective way of evaluating a newborn baby's condition. In a partially separate study, 100 consecutive babies were evaluated (Table VIII).

Since only a very few newborn babies' hands are pink at one minute, I have not given any infant a 10 score. The only infant with a score lower than 6 was a 22 week, 1 pound newborn infant who had only a faint heartbeat and died in 55 minutes.

5. Neonatal morbidity is an important indicator in evaluating trauma of pregnancy, delivery, analgesics, and anesthesia. Eighteen infants had neonatal complications which they survived. Six had congenital malformations of the heart. Eleven had minor complications, but all recovered completely and were discharged with the mother (Table IX).

One infant did poorly from birth, needed resuscitation in the delivery room, and remained limp with episodes of cyanosis. It was transferred to a university pediatric department and was discharged with a diagnosis of spastic paraplegia, cause undetermined. This patient had bleeding early in pregnancy and at two occasions took a large amount of an undetermined drug. In labor she was

given no analgesia and a total of 500 mg. of pentobarbital divided into three doses and spontaneous delivery took place following a slightly prolonged second stage.

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Discussion

Dr. Hugh A. McAllister, Lumberton, North Carolina. It is somewhat encouraging to know that the search for a safe, sound, and satisfactory anesthesia for the parturient female continues. In general, the smaller the hospital, the less chance there is of satisfactory anesthesia in delivery rooms.

Dr. Seear shows in Table II the number of patients receiving meperidine and various tranquilizers and in various doses but does not tell us his criteria for when to give the medication, the necessity for repeating it, and how he decides on the need and the dose for the second administration. The same is true of his administration of pentobarbital. How early in labor should it be given? Should the condition of the cervix and the vigor of labor be deciding factors?

Since our experience has been totally with sodium pentothal which is an ultrashort-acting barbiturate and since it is the sulfur analogue of pentobarbital sodium, I should like to briefly show our experience with that drug, and I feel that our experience with sodium pentothal and his with pentobarbital sodium should not differ greatly.

In 1955, Dr. Charles E. Flowers, Jr., and I reported on the use of sodium pentothal in 7,793 deliveries between the years of 1948 and 1955 showing that for the last 5 years of that period 82 per cent of the deliveries at Southeastern General Hospital were done under sodium pentothal. Since then, an additional 23,723 deliveries have been done with approximately 95 per cent being done under sodium pentothal. It is my feeling that 35,311 deliveries with approximately 90 per cent being done under thiopental signifies the acceptance of the obstetric staff and the patients in our community.

This critical analysis of our work should also fully apply to Dr. Seear's work with pentobarbital.

Pentothal sodium is a thiobarbiturate which is primarily a parasympathomimetic hypnotic but when used in conjunction with nitrous oxide, oxygen, cyclopropane, ether, and conduction anesthesia, it becomes a useful agent in the practice of anesthesia. Being a parasympathomimetic, laryngospasm could be easily produced by perineal stretching at the time of delivery. Being primarily a hypnotic, it would seem that profound cerebral depression would be necessary to alleviate the pain of a parturition. Being a potent hypnotic, fetal depression could be an undesirable complication. Apparently, however, thiopental is a useful agent in obstetrics.

When pentothal sodium is used intermittently and intelligently in patients who have not ingested a recent meal and have had parasympathetic depression by scopolamine, atropine, or the like, laryngospasm is not a significant complication. There were no maternal deaths due to anesthesia and no serious laryngospasms in this series. Conservative doses of 5 per cent pentothal give sufficient cerebral depression to alleviate pain but apparently not sufficient to depress the more primitive medullary centers. Solutions of 2.5 per cent are less satisfactory and are not recommended for thiopental hypnosis for delivery.

The lack of fetal depression is more difficult to explain. The rapid passage of thiobarbiturates across the placenta is a fact. The rapid disappearance of thiopental from the bloodstream and its concentration in body fat is likewise well established.

There is no real correlation between infant blood level of pentothal and the reaction time of the infant. Intermittent injection of pentothal, the rapid dispersal of pentothal in the tissue spaces and fat and the unpredictable placental circulation at time of delivery can account for these variations. It is factual, though not easily understandable, that despite almost equal blood concentrations of pentothal in the mother and the fetus, a vigorous crying infant can be delivered of a mother who is asleep. To explain this one must think hypothetically. Thiobarbiturates rapidly leave the bloodstream and enter tissue spaces.

If only a small amount of pentothal is used, time is not a factor in fetal depression, since the pentothal will leave both maternal and infant circulation rapidly. However, if large intermittent doses are employed over prolonged periods of time, tissue saturation may occur and pentothal can then be responsible for depression in the infant. In this series small doses were used for short times.

A second factor may be the presence of drug tolerance and adaptability of a newborn infant. Possibly, the primitive urge to establish extrauterine respiration is profound. The fact that only 5 per cent of the infants required resuscitation may be a sampling error. However, this low figure may also be indicative of the safety of the technic. Moreover, in the entire series of the first 7,793 deliveries, there were no infant deaths that were attributable to anesthesia per se. The last 23,723 deliveries have not been completely analyzed. It is evident that the majority of the patients received less than 300 mg. of pentothal and were anesthetized less than 5 minutes prior to delivery.

It seems to me that prerequisites for any type anesthesia, in general, and pentothal or pentobarbital, in particular, should be:

1. The patient should not have ingested solid food less than 2 hours before onset of labor.

2. Oxygen should be administered with pentothal sodium (or pentobarbital) since the arterial oxygen saturation may fall during its administration.

3. Persons who are responsible for pentothal (or pentobarbital) anesthesia should have both the materials necessary and the technical knowledge to treat laryngospasm.

4. The administration of pentothal sodium should be delayed until the total amount of pentothal which is given prior to delivery should not exceed 0.5 Gm.

Our method of administration of pentothal is as follows: 1 Gm. of pentothal is mixed with 20 c.c. of distilled water to make a 5 per cent solution. The resulting solution contains 50 mg. per cubic millimeter.

The initial dose should not exceed 200 mg. in the first 30 to 60 seconds. Anesthesia is maintained with intermittent doses of 50 mg. No attempt is made to predetermine the total dose required. There is wide variation in the individual tolerance to thiobarbiturates. All drugs should be given by vein and not intramuscularly.

Pentothal anesthesia in obstetrics should be used in combination with a pudendal block, paracervical block, or at least local perineal infiltration for maximum efficiency. Although in our series many operative procedures were attempted it is not our feeling that forceps rotation, delivery of a complicated breech, version and extraction of a second twin, or other real obstetric problems should be attempted under pentothal alone because adequate relaxation is not possible.

That barbiturates do have a place in obstetric delivery is in my mind a certainty but just what place remains somewhat of a question. Certainly pentothal is safer, far more esthetic than most inhalation types of anesthesia with obstructed breathing, slow induction, and postdelivery nausea, and we will certainly welcome continued observation of this useful drug to more completely establish its value in our chosen field.

DR. JOHN C. BURWELL, Greensboro, North Carolina. Dr. Seear has presented further evidence of the efficacy and safety of intravenous barbiturates for labor and delivery. He has used other synergistic drugs to obtain analgesia as well as anesthesia. The results, compiled over a period of years, bear out the findings of other investigators and substantiate contentions regarding length of labor, bleeding, fetal depression, morbidity, and mortality.

In our own experience, we have found that intravenous barbiturates provide an adequate margin of safety with a satisfactory degree of anesthesia. We have not used the intravenous administration for analgesia. We are in complete accord with the author's statement that "Ideally

all obstetric anesthesia should be administered by an anesthesiologist trained in obstetric anesthesia." At the same time, the intravenous barbiturates do provide maternal pain relief where more sophisticated coverage is unavailable, and the author's careful and comprehensive studies are a definite contribution to our knowledge of the subject.

DR. SEEAR (Closing). To Dr. McAllister's question, I can say that I do not adhere strictly to a routine but give meperidine and propiomazine when labor is well established, as proved by progressive effacement and dilatation of the cervix and regular, painful contractions, usually when the cervix is from 2 to 4 cm. dilated.

Pentobarbital is given when the patient again becomes complaining, usually when the cervix is from 5 to 8 cm. dilated, and additional pentobarbital is given if the patient becomes alert before she is ready for delivery.

EXHIBIT 6



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TABLE 12.5 Sedative-Hypnotic Barbiturates

Generic Name	Trade Name
Ultrashort Acting	
methohexital	Brevital
thiopental	Pentothal
Short Acting	
pentobarbital	Nembutal
secobarbital	Seconal
Intermediate Acting	
butabarbital	Butisol
Long Acting	
phenobarbital	Generic
mephobarbital	Mebaral

cerebral cortex. Their ability to inhibit nerve impulse transmission is due in part to their ability to potentiate the action of the inhibitory neurotransmitter GABA, which is found in high concentrations in the CNS. Barbiturates also raise the seizure threshold and can be used to treat seizures (see Chapter 14).

Indications

All barbiturates have the same sedative-hypnotic effects but differ in their potency, time to onset of action, and duration of action. It is important to note that the use of barbiturates is no longer recommended for sleep induction. The various categories of barbiturates can be used for the following therapeutic purposes: (1) ultrashort acting: anesthesia for short surgical procedures, anesthesia induction, control of convulsions, and reduction of intracranial pressure in neurosurgical patients; (2) short acting: sedation and control of convulsive conditions; (3) intermediate acting: sedation and control of convulsive conditions; and (4) long acting: epileptic seizure prophylaxis.

Contraindications

Contraindications to barbiturate use include known drug allergy, pregnancy, significant respiratory difficulties, and severe kidney or liver disease. These drugs must be used with caution in older adults due to their sedative properties and increased fall risk.

Adverse Effects

Adverse effects of barbiturates relate to the CNS and include drowsiness, lethargy, dizziness, hangover, and paradoxical restlessness or excitement. Their long-term effects on normal sleep architecture can be detrimental. Barbiturates deprive people of REM sleep, which can result in agitation. When any barbiturate is stopped, a rebound phenomenon may occur. During this rebound, the proportion of REM sleep is increased and nightmares often ensue. Common adverse effects of barbiturates are listed in Table 12.6. As is the case with most sedative drugs, barbiturates are associated with an increased incidence of falls when used in older adults. If they are recommended for older adults at all, the usual dose is reduced by half whenever possible.

TABLE 12.6 Barbiturates: Adverse Effects

Body System	Adverse Effects
Cardiovascular	Vasodilation and hypotension, especially if given too rapidly
Gastrointestinal	Nausea, vomiting, diarrhea, constipation
Hematologic	Agranulocytosis, thrombocytopenia
Nervous	Drowsiness, lethargy, vertigo
Respiratory	Respiratory depression, cough
Other	Hypersensitivity reactions: urticaria, angioedema, rash, fever, Stevens-Johnson syndrome

Toxicity and Management of Overdose

Treatment of an overdose is mainly symptomatic and supportive. The mainstays of therapy are maintenance of an adequate airway, assisted ventilation, and oxygen administration if needed, along with fluid and pressor support as indicated. Activated charcoal may be given; however, recent clinical data do not support its use because no improvement in clinical outcome has been shown. Phenobarbital and mephobarbital are relatively acidic and can be eliminated more quickly by the kidneys when the urine is alkalized (pH is raised). This keeps the drug in the urine and prevents it from being resorbed back into the circulation. Alkalization, along with forced diuresis using diuretics (e.g., furosemide [see Chapter 28]), can hasten elimination of the barbiturate.

Interactions

Barbiturates as a class are notorious enzyme inducers. They stimulate the action of enzymes in the liver that are responsible for the metabolism or breakdown of many drugs. By stimulating the action of these enzymes, they cause many drugs to be metabolized more quickly, which usually shortens their duration of action. Barbiturates increase the activity of hepatic microsomal or cytochrome P-450 enzymes (see Chapter 2). This process is called *enzyme induction*. Induction of this enzyme system results in increased drug metabolism and breakdown. However, if two drugs are competing for the same enzyme system, the result can be inhibited drug metabolism and possibly increased toxicity for the wide variety of drugs that are metabolized by these enzymes. Other drugs that are enzyme inducers are rifampin and phenytoin.

Additive CNS depression occurs with the coadministration of barbiturates with alcohol, antihistamines, benzodiazepines, opioids, and tranquilizers. Drugs most likely to have marked interactions with the barbiturates include monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants (see Chapter 16), anticoagulants (see Chapter 26), glucocorticoids (see Chapter 30), and oral contraceptives (see Chapter 34) with barbiturates. Coadministration of MAOIs and barbiturates can result in prolonged barbiturate effects. Coadministration of anticoagulants with barbiturates can result in decreased anticoagulation response and possible clot formation. Coadministration of barbiturates with oral contraceptives can result in accelerated metabolism of the contraceptive drug and possible unintended pregnancy. Women taking both types of medication concurrently need to

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TABLE 12.7 Barbiturates: Controlled Substance Schedule

Schedule	Barbiturates
C-II	pentobarbital, secobarbital
C-III	butabarbital, thiopental
C-IV	mephobarbital, methohexital, phenobarbital

be advised to consider an additional method of contraception as a backup.

Dosages

Barbiturates can act as either sedatives or hypnotics, depending on the dosage. For information on selected barbiturates and their recommended sedative and hypnotic dosages, see the following table.

Dosages

Selected Barbiturates

Drug	Onset and Duration	Usual Dosage Adult Range	Indications/ Uses
pentobarbital (Nembutal)	Short acting	IM: 150–200 mg IV: 100 mg	Preoperative sedative
phenobarbital	Long acting	PO: 30–120 mg/day divided IM/IV: 100–200 mg 60–90 min before surgery	Sedative Preoperative sedative

DRUG PROFILES

Like benzodiazepines, barbiturates can also have varied uses, including preoperative sedation, anesthesia adjunct, and anticonvulsant therapy. All barbiturates are controlled substances, but not all are on the same schedule, as illustrated in Table 12.7. Dosage information appears in the dosages table for barbiturates.

pentobarbital

Pentobarbital (Nembutal) is a short-acting barbiturate. Formerly prescribed as a sedative-hypnotic for insomnia, pentobarbital is now principally used preoperatively to relieve anxiety and provide sedation. In addition, it is used occasionally to control status epilepticus. Pentobarbital may also be used to treat withdrawal symptoms in patients who are physically dependent on barbiturates or nonbarbiturate hypnotics. It is available in oral, injectable, and rectal dosage forms.

Pharmacokinetics: Pentobarbital

Route	Onset of Action	Peak plasma Concentration	Elimination Half-Life	Duration of Action
PO	30–60 min	1–2 hr	20–45 min	3–4 hr

phenobarbital

Phenobarbital is considered the prototypical barbiturate and is classified as a long-acting drug. Phenobarbital is used for the prevention of generalized tonic-clonic seizures and fever-induced convulsions. In addition, it has been useful in the treatment of hyperbilirubinemia in neonates. Currently it is only rarely used as a sedative and is no longer recommended to be used as a hypnotic drug. It is available in oral and injectable forms.

Pharmacokinetics: Phenobarbital

Route	Onset of Action	Peak Plasma Concentration	Elimination Half-Life	Duration of Action
IV	5 min	30 min	50–120 hr	6–12 hr
PO	30 min	1–6 hr	50–120 hr	6–12 hr

OVER-THE-COUNTER HYPNOTICS

Nonprescription sleeping aids often contain antihistamines (see Chapter 36). These drugs have a CNS depressant effect. The most common antihistamines contained in over-the-counter sleeping aids are doxylamine (Unisom) and diphenhydramine (Sominex). Analgesics (e.g., acetaminophen [see Chapter 10]) are sometimes added to offer some pain relief if pain is a component of the sleep disturbance (e.g., acetaminophen/diphenhydramine [Extra Strength Tylenol PM]). As with other CNS depressants, concurrent use of alcohol can cause additive CNS depression.

MUSCLE RELAXANTS

A variety of conditions such as trauma, inflammation, anxiety, and pain can be associated with acute muscle spasms. The muscle relaxants are a group of compounds that act predominantly within the CNS to relieve pain associated with skeletal muscle spasms. Most muscle relaxants are known as *centrally acting* skeletal muscle relaxants because their site of action is the CNS. Centrally acting skeletal muscle relaxants are similar in structure and action to other CNS depressants such as diazepam. It is believed that the muscle relaxant effects are related to this CNS depressant activity. Only one of these compounds, dantrolene, acts directly on skeletal muscle. It belongs to a group of relaxants known as direct-acting skeletal muscle relaxants. It closely resembles GABA.

Mechanism of Action and Drug Effects

The majority of the muscle relaxants work within the CNS. Their beneficial effects are believed to come from their sedative effects rather than from direct muscle relaxation. Dantrolene acts directly on the excitation-contraction coupling of muscle fibers and not at the level of the CNS. It directly affects skeletal muscles by decreasing the response of the muscle to stimuli. It appears to exert its action by decreasing the amount of calcium released from storage sites in the sarcoplasmic reticula of muscle fibers. All other muscle relaxants have no direct effects on muscles, nerve conduction, or muscle-nerve junctions and have a depressant effect on the CNS. Their effects are the result of CNS depression in the brain primarily at the level of the brainstem, thalamus, and basal ganglia and also at the spinal cord. The effects of muscle relaxants are relaxation of striated muscles,

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V. BARBITURATES

The barbiturates were formerly the mainstay of treatment to sedate the patient or to induce and maintain sleep. Today, they have been largely replaced by the benzodiazepines, primarily because barbiturates induce tolerance, drug-metabolizing enzymes, physical dependence, and are associated with very severe withdrawal symptoms. Foremost is their ability to cause coma in toxic doses. Certain barbiturates, such as the very short-acting *thiopental*, are still used to induce anesthesia (see p. 135).

A. Mechanism of action

The sedative-hypnotic action of the barbiturates is due to their interaction with $GABA_A$ receptors, which enhances GABAergic transmission. The binding site is distinct from that of the benzodiazepines. Barbiturates potentiate GABA action on chloride entry into the neuron by prolonging the duration of the chloride channel openings. In addition, barbiturates can block excitatory glutamate receptors. Anesthetic concentrations of *pentobarbital* also block high-frequency sodium channels. All of these molecular actions lead to decreased neuronal activity.

B. Actions

Barbiturates are classified according to their duration of action (Figure 9.7). For example, *thiopental* [thye-oh-PEN-tal], which acts within seconds and has a duration of action of about 30 minutes, is used in the intravenous induction of anesthesia. By contrast, *phenobarbital* [fee-noe-BAR-bi-tal], which has a duration of action greater than a day, is useful in the treatment of seizures (see p. 178). *Pentobarbital* [pen-toe-BAR-bi-tal], *secobarbital* [see-koe-BAR-bi-tal], and *amobarbital* [am-oh-BAR-bi-tal] are short-acting barbiturates, which are effective as sedative and hypnotic (but not antianxiety) agents.

1. **Depression of CNS:** At low doses, the barbiturates produce sedation (calming effect, reducing excitement). At higher doses, the drugs cause hypnosis, followed by anesthesia (loss of feeling or sensation), and finally, coma and death. Thus, any degree of depression of the CNS is possible, depending on the dose. Barbiturates do not raise the pain threshold and have no analgesic properties. They may even exacerbate pain. Chronic use leads to tolerance.

2. **Respiratory depression:** Barbiturates suppress the hypoxic and chemoreceptor response to CO_2, and overdosage is followed by respiratory depression and death.

3. **Enzyme induction:** Barbiturates induce P450 microsomal enzymes in the liver. Therefore, chronic barbiturate administration diminishes the action of many drugs that are dependent on P450 metabolism to reduce their concentration.

C. Therapeutic uses

1. **Anesthesia:** Selection of a barbiturate is strongly influenced by the desired duration of action. The ultrashort-acting barbiturates, such as *thiopental*, are used intravenously to induce anesthesia.

2. **Anticonvulsant:** *Phenobarbital* is used in long-term management of tonic-clonic seizures, status epilepticus, and eclampsia. *Phenobarbital* has been regarded as the drug of choice for treatment of young chil-

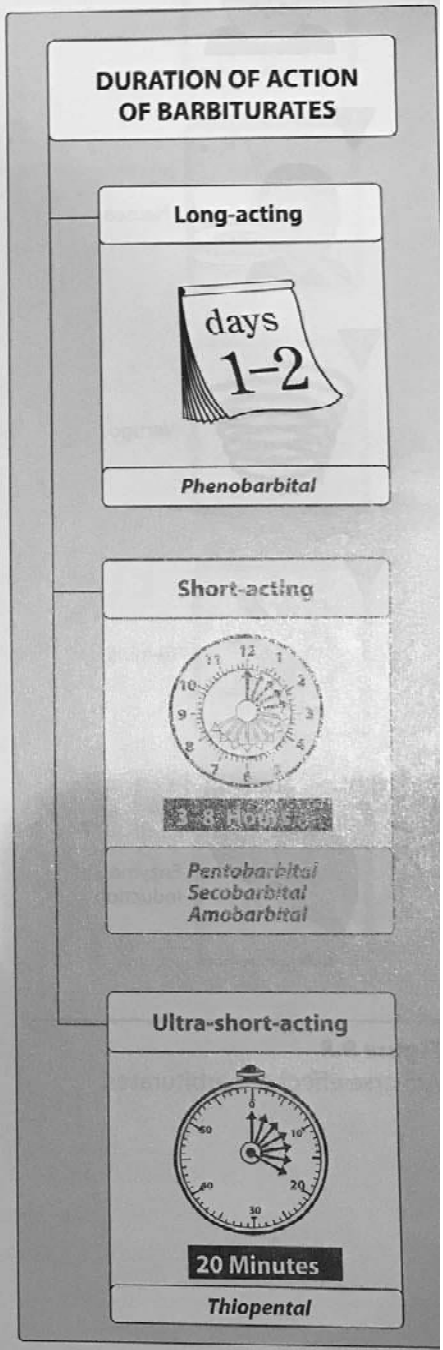


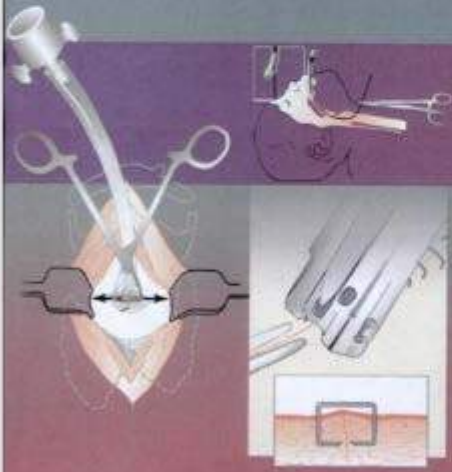
Figure 9.7
Barbiturates classified according to their durations of action.

EXHIBIT 8

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is most effective when administered to a child with an empty stomach. Absorption may be erratic in those who have recently eaten, leading to an unpredictable onset of action and depth of sedation. The usual dose is 0.2 to 0.6 mg/kg, and the maximum clinical effect may not occur for 25 to 40 minutes.

The major complication of benzodiazepines is respiratory depression, which is almost exclusively associated with intravenous administration although is occasionally reported with intramuscular injections. Complications are minimal when benzodiazepines are used as a single agent or when they are administered by the oral or nasal route. However, because benzodiazepines act synergistically with narcotics and barbiturates, their effects—and potential complications—are increased when they are used in conjunction with these other agents. In addition, some children who receive benzodiazepines experience a so-called "paradoxical" reaction. Rather than being sedated, these patients become more anxious and agitated after administration of the medication. In such cases, it appears that the child predominately experiences the disinhibitory effect of the drug instead of the sedative effect. Although paradoxical reactions can be reversed with flumazenil, they may also respond favorably to administration of additional benzodiazepine.

Flumazenil is a benzodiazepine antagonist that blocks the activity of benzodiazepines at CNS receptor sites (35). Its use in the pediatric population has not been widely studied. It may be appropriate in iatrogenic overdose or when adverse side effects are experienced but is not recommended for routine use to reduce the duration of benzodiazepine-induced sedation. The pediatric dose of flumazenil is 0.02 mg/kg, given by slow intravenous infusion, up to a maximum of 1 mg. The onset of action is within 1 to 3 minutes. Patients must be monitored closely for resedation because the effects of flumazenil subside before the sedative effects of the benzodiazepine. Additionally, flumazenil itself has some potential untoward effects. Most are minor and include crying, agitation, headache, and dizziness. However, it has rarely been associated with seizures.

Barbiturates

Barbiturates are sedative-hypnotics that act as general depressants of the central and peripheral nervous systems and of skeletal, smooth, and cardiac muscles. Their clinical effects are dose dependent and vary widely from mild sedation to coma. Barbiturates can be divided into four groups: ultrashort-acting (thiopental and methohexital), short-acting (pentobarbital), intermediate (butabarbital), and long-acting (phenobarbital). Generally, the ultrashort-acting and short-acting barbiturates are utilized for procedural sedation. When used alone at the proper sedative dose, adverse side effects are rare. Higher doses (e.g., a preintubation dose of methohexital) can, however, cause apnea, transient hypotension, and bradycardia. Barbiturates have no analgesic qualities when used at sedative doses; analgesia is only provided when high anesthetic doses are administered. Thus, when the patient is anticipated to experience pain, an additional analgesic (parenteral or local) must be used.

Methohexital Methohexital is an ultrashort-acting barbiturate that can be given rectally for brief, painless procedures or procedures with which local anesthetic will be used. The onset of action is approximately 8 minutes. When used as a sedative for painless procedures (e.g., CT scan, MRI), it is 95% effective (36). The methohexital dose is 25 mg/kg per rectum, up to a maximum dose of 1 g. Adverse events include hypoventilation and oxygen desaturation, hiccups, cough, and hypersalivation. Although methohexital can also be given by intravenous injection, there are few data regarding this route of administration for pediatric procedural sedation. Furthermore, safer alternative agents are available.

Pentobarbital Pentobarbital is a short-acting barbiturate that is useful for longer procedures or as a preoperative sedative. It can be used in conjunction with an analgesic for painful procedures and may be given parenterally, orally, or rectally. When administered as an intravenous injection, onset of action for pentobarbital occurs in approximately 6 minutes, and the duration of effect is approximately 60 minutes. Oral administration and rectal administration are associated with a delayed onset of sedation (up to 45 minutes). Successful sedation occurs in approximately 99% of patients, but the best sedation results are seen in children younger than 8 years of age (33,37). The oral, rectal, or intramuscular dose of pentobarbital is 2 to 6 mg/kg, up to a maximum dose of 150 mg. The intravenous dose of pentobarbital is 1 to 3 mg/kg. Adverse events associated with pentobarbital administration include respiratory depression, emergence reactions, and paradoxical hyperactivity.

Chloral Hydrate

Chloral hydrate is a sedative-hypnotic CNS depressant used in children as a sedative for procedures which are painless but require cooperation, such as a CT scan, MRI, or electroencephalogram (EEG). It can also be used in conjunction with a local anesthetic for mildly painful procedures such as minor dental work or wound repair (31,38). The drug is readily absorbed through the gastrointestinal tract and may be administered orally or rectally. The dose is 25 to 100 mg/kg, up to a maximum of 1 g in infants and 2 g in children. Peak therapeutic levels occur in approximately 30 to 60 minutes. Chloral hydrate is metabolized in the liver to its active metabolite, trichloroethanol. The elimination half-life of this metabolite is 8 to 12 hours.

When chloral hydrate is administered in low doses (e.g., 25 mg/kg) for light sedation, monitoring beyond the initial period of sedation need only consist of periodic assessment of vital signs. Patients given higher doses of the drug (50 to 100 mg/kg) should be monitored with continuous pulse oximetry. Adverse side effects include excessive somnolence and paradoxical excitation. Major disadvantages of chloral hydrate use include lack of a reversal agent, unpredictable onset and degree of sedation, and a long half-life that requires a protracted period of monitoring.

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is not formed from α-hydroxyamines. However, the requirement for amphetamine ≥200 ng/mL may not be satisfied in some cases of known methamphetamine ingestion, especially during the initial 12 hours postdose period, leading to false-negative results.[457,490] To increase detection rate for amphetamine and methamphetamine, SAMHSA has proposed[432] a reduction of the screening and confirmation cutoff from 1000 ng/mL and 500 ng/mL to 500 ng/mL and 250 ng/mL, respectively. Methamphetamine would require the presence of at least 100 ng/mL amphetamine metabolite for a positive result. In a 2002 study,[345] these lower cutoff values increased the detection rate for methamphetamine by 48% compared with current cutoff values. Moreover, the highest detection rate for methamphetamine was achieved by use of the 250 ng/mL cutoff with elimination of the amphetamine requirement. In the described procedure, periodate oxidation before derivatization destroys α-hydroxyamines and therefore eliminates possible false report of methamphetamine owing to their presence.[147]

Barbiturates

The barbiturates have a low therapeutic index and a relatively high abuse potential. Because of their rapid onset and short duration of action, the short- to intermediate-acting barbiturates are used as sedative-hypnotics (amobarbital, butabarbital, butalbital, pentobarbital, and secobarbital) and are those most commonly abused. The longer acting barbiturates (mephobarbital and phenobarbital), used primarily for their anticonvulsant properties, are rarely abused.

Pharmacological Response

Barbiturates suppress CNS neuronal activity and thus have sedative and hypnotic properties.[186] This CNS suppression is a result of barbiturate-enhanced activation of the inhibitory GABA-ergic neuronal system mediated by the neurotransmitter γ-aminobutyric acid (GABA).[86] Postsynatic $GABA_A$ receptors are multisubunit transmembrane Cl^- conductance channels, which when activated by GABA open to allow flow of Cl^- into the neuron, with subsequent hyperpolarization and inhibition of electrical transmission. At low dose, some barbiturates bind to the $GABA_A$ receptors and enhance their response to GABA. At a higher dose, barbiturate binding results in prolonged opening of the Cl^- channel, without the necessity for GABA binding. In addition, barbiturates suppress excitatory glutamate-responsive AMPA (alpha-amino-3-OH-4-isoxozole propionic acid) ion-gated receptor subtypes.

Because of their low therapeutic index and high potential for abuse, the barbiturates have largely been replaced by the safer benzodiazepines for sedative and hypnotic purposes. Nevertheless, they continue to be available for this purpose or in combination with other analgesic, antihypertensive, antiasthmatic, antispasmodic, or antidiuretic drugs. The combination of barbiturates, such as butalbital with analgesic preparations, is ironic. Not only do barbiturates lack analgesic properties, but at low doses they antagonize the effects of analgesics. Phenobarbital is effective as an anticonvulsant drug (see Chapter 33), and short- and ultrashort-acting barbiturates (Table 34-10) are used for IV anesthesia. Anesthetic doses of barbiturates, such as pentobarbital, are also used to reduce intracranial pressure from cerebral edema associated with head trauma, surgery, or cerebral ischemia.[295] For the induction of this therapeutic coma, sufficient pentobarbital is administered IV to achieve a serum pentobarbital concentration between about 20 and 50 μg/mL. Therefore appropriate analytical methods are necessary to monitor serum pentobarbital concentrations in these circumstances. Moreover, barbiturates continue to be subject to abuse and are a source of intentional or, less commonly, accidental drug intoxication. Measurement of the common barbiturates in serum or urine can aid in the diagnosis and management of barbiturate intoxication.

The general formula for barbiturates is given in Table 34-10. Any change in the constituents at position five that confers an increase in lipid solubility typically results in increased onset of action, decreased duration of action, and increased potency. Moreover an increase in hydrophobic properties also leads to more rapid and extensive hepatic metabolic clearance and thus to decreased urinary elimination of an unchanged drug.

The classification of barbiturates as "ultrashort-acting," "short-acting," "intermediate-acting," and "long-acting" refers to the duration of effect and not to the elimination half-life. The duration of action is determined by the rate of distribution into brain and subsequent redistribution to other tissues.[86]

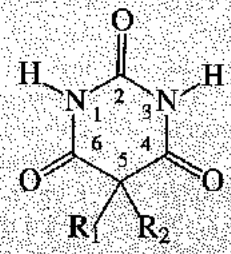
The major manifestations of barbiturate intoxication are CNS, cardiovascular, and respiratory depression. Severe intoxication results in coma, hypothermia, hypotension, and cardiorespiratory arrest.

Appropriate treatment for barbiturate intoxication includes general cardiopulmonary support and measures to prevent further drug absorption and to enhance elimination. Urine alkalinization may enhance the elimination of long-acting barbiturates (e.g., phenobarbital and barbital) but has little effect on intermediate-, short-, or ultrashort-acting barbiturates.

Once filtered by the glomerulus, a nonionized drug may be appreciably reabsorbed by the tubules. The goal of alkalinization is to maintain the urine pH between 7.5 and 8.5. In this pH range, a large fraction of an acidic drug will be ionized, and its elimination in urine will thus be enhanced.

For urine alkalinization to be effective, the drug should have low plasma protein binding, be appreciably eliminated in urine as an unchanged drug, and have a pK_a below 7.4. From an examination of Table 34-10, only phenobarbital (and other long-acting barbiturates [e.g., barbital]) fulfills these criteria. The primary route of elimination of ultrashort-, short-, and intermediate-acting barbiturates is by hepatic metabolism. Thus with the exception of aprobarbital, only small amounts are eliminated in urine as an unchanged drug. Moreover, at pH 8.0, only about 50% of a

TABLE 34-10 Characteristics of Barbiturates



Barbiturate	Duration of Action (hr)	Half-life (hr)	Therapeutic Concentration (μg/mL)	Toxic Concentration (μg/mL)	% Protein Bound	% Excreted Unchanged in Urine	pK_a	R_1	R_2
Ultrashort-Acting									
Thiopental*	0.5	6-7	1-5 (hypnotic) 7-130 (anesthesia)	>10	75-90	0.3	7.6	$-CH_2CH_3$	$-CHCH_2CH_2CH_3$ CH_3
Short-Acting									
Butalbital	3-4	34-42	–	–	26	3	7.9	$-CH_2CH{=}CH_2$	$-CH_2CHCH_3$ CH_3
Pentobarbital	3-4	15-30	1-5	>10	65	1	7.9	$-CH_2CH_3$	$-CHCH_2CH_2CH_3$ CH_3
Secobarbital	3-4	19-34	1-2	>5	46-70	5	7.9	$-CH_2CH{=}CH_2$	$-CHCH_2CH_2CH_3$ CH_3
Intermediate-Acting									
Amobarbital	6-8	8-42	1-5	>10	59	1-3	7.9	$-CH_2CH_3$	$-CH_2CH_2CHCH_3$ CH_3
Aprobarbital	6-8	14-34	–	–	55-70	13-24	8.1	$-CH_2CH{=}CH_2$	$-CHCH_3$ CH_3
Butabarbital	6-8	34-42	–	–	26	5-9	7.9	$-CH_2CH_3$	$-CHCH_2CH_3$ CH_3
Long-Acting									
Phenobarbital	10-12	40-140	15-40	>65	45-50	25-33	7.2	$-CH_2CH_3$	$-C_6H_5$

Data from Baselt RC. Disposition of toxic drugs and chemicals in man. 7th ed. Foster City, CA: Biomedical Publications, 2004; Tietz NW, Ed. Clinical guide to laboratory tests. Philadelphia: WB Saunders Co, 1995; and Physician's desk reference. 56th ed. Montvale, NJ: Medical Economics, 2002.
*Oxygen at position 2 is replaced by sulfur.

short- or intermediate-acting barbiturate (pK_a 7.9 to 8.1) is ionized, whereas phenobarbital (pK_a 7.2) is about 85% ionized. Hemodialysis is effective in increasing the elimination of all barbiturates. However, it is more effective for long-acting barbiturates than for shorter-acting barbiturates because of differences in their lipid solubility and protein binding. Whereas urine alkalinization may increase the elimination of phenobarbital somewhat, it is considerably less effective than the process referred to as GI dialysis, which is mediated by the repeated oral administration of activated charcoal (multiple-dose activated charcoal, MDAC).[9,131]

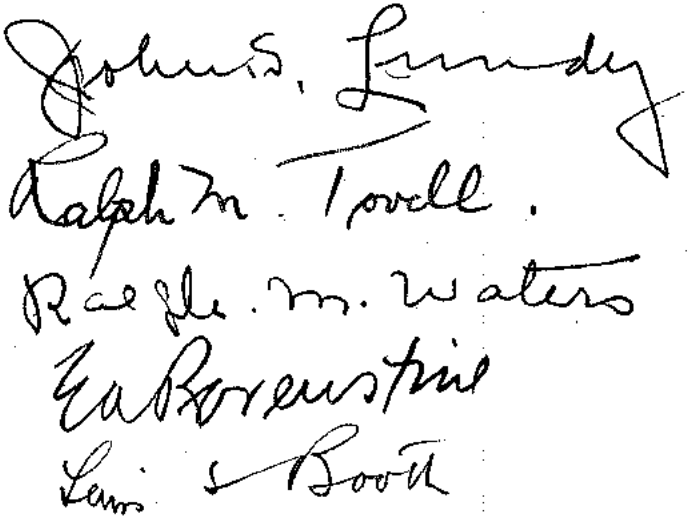
The rationale for MDAC therapy is that drug secreted into the GI tract (along with a previously unabsorbed drug) is bound by charcoal and thus cannot be reabsorbed. Drugs that are amenable to this process are ones that have a small volume of distribution, low protein binding, and a prolonged elimination $t_{1/2}$ following overdose. Currently, MDAC is recommended only for the treatment of serious phenobarbital, theophylline, carbamazepine, quinine, and dapsone overdose.[9]

The barbiturates undergo extensive hepatic metabolism in which the C5 substituents are transformed to alcohols, phenols, ketones, or carboxylic acids; these metabolites may be excreted in urine in part as glucuronide conjugates. For some barbiturates (amobarbital and phenobarbital), *N*-glucosylation is an additional important metabolic trans-

EXHIBIT 10

Fundamentals of ANESTHESIA

AN OUTLINE



Fundamentals

of

ANESTHESIA

AN OUTLINE

By

SUBCOMMITTEE ON ANESTHESIA OF
NATIONAL RESEARCH COUNCIL

Ralph M. Waters, Chm.
John S. Lundy
Lewis S. Booth
Ralph M. Tovell
E. A. Rovenstine

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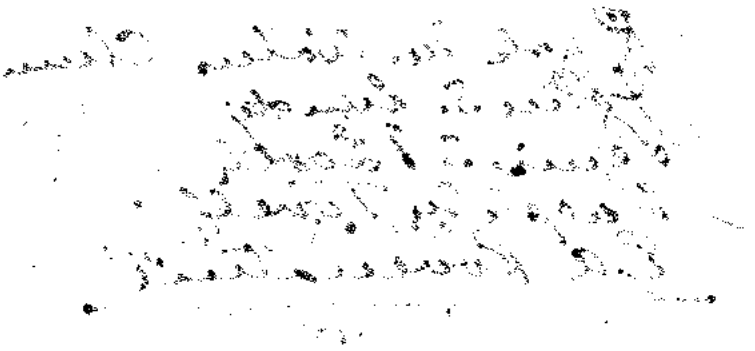
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BARBITURIC ACID DERIVATIVES

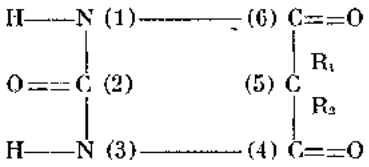


Fig. 20.—The structural formula of barbituric acid. Following is a comparison of certain barbituric acid derivatives, showing how they differ in chemical structure. The barbituric acid derivatives are listed in the order of decreasing duration of action. The numbers which head the columns in the table below refer to the numbers that designate position in the structural formula.

DURATION			(5) (R_1)	(5) (R_2)	(1)	(2)
Increase	LONG	Phenobarbital (Luminal) .... U.S.P.	ethyl	phenyl		
		Barbital (medinal; veronal) . U.S.P.	ethyl	ethyl		
	INTERMEDIATE	Dial..... N.N.R.	allyl	allyl		
		Ipral..... N.N.R.	ethyl	isopropyl		
		Calcium Sodium				
		Alurate..... N.N.R.	allyl	isopropyl		
		Neonal..... N.N.R.	ethyl	n-butyl		
	SHORT	Nostal..... N.N.R.	bromallyl	isopropyl		
		Amytal..... N.N.R.	ethyl	isoamyl		
		Sandoptal..... N.N.R.	allyl	isobutyl		
		Pernoston..... N.N.R.	bromallyl	Betabutyl		
		Pentobarbital (Nembutal)... N.N.R.	ethyl	l-methylbutyl		
		Phanodorn..... N.N.R.	ethyl	cyclohexenyl		
Decrease		Ortal-sodium..... N.N.R.	ethyl	n-hexyl		
	ULTRA SHORT	Evipal.....	methyl	cyclohexenyl	methyl	
		Pentothal sodium..... N.N.R.	ethyl	l-methylbutyl		thio

IN THE SUPREME COURT
STATE OF SOUTH DAKOTA

CHARLES RUSSELL RHINES, Plaintiffs vs. SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, SECRETARY, SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, and DARIN YOUNG IN HIS CAPACITY AS WARDEN OF THE SOUTH DAKOTA STATE PENITENTIARY. Defendants.	App. No. _____ **THIS IS A CAPITAL CASE EXECUTION SET FOR BETWEEN NOVEMBER 3, 2019 AND NOVEMBER 9, 2019**

AFFIDAVIT OF DANIEL R. FRITZ

STATE OF SOUTH DAKOTA)
:SS
COUNTY OF MINNEHAHA)

Daniel R. Fritz, being first duly sworn on oath, states and alleges as follows:

1. I am an attorney for Plaintiff Charles Russell Rhines in the above-captioned case, and I have knowledge of the matters herein.
2. Attached hereto as Exhibit 1 is a true and correct copy of selected pages I received from the Office of the Attorney General that were attached to a letter from the Attorney General dated August 8, 2019.

Dated this 1st day of November 2019.

_____
Daniel R. Fritz

Subscribed and sworn to before me this 1st day of November, 2019.

(SEAL)

_____
Notary Public – South Dakota

STATE OF SOUTH DAKOTA

OFFICE OF ATTORNEY GENERAL
1302 East Highway 14, Suite 1
Pierre, South Dakota 57501-8501
Phone (605) 773-3215
Fax (605) 773-4106
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www.state.sd.us/atg

MARTY J. JACKLEY
ATTORNEY GENERAL

CHARLES D. McGUIGAN
CHIEF DEPUTY ATTORNEY GENERAL

April 17, 2012

Domenic J. Veneziano
Director, Division of Import Operations and Policy
Department of Health and Human Services
Food & Drug Administration
12420 Parklawn Drive, Room 3109
Rockville, MD 20857

Dear Director Veneziano:

I would like to take this opportunity to address your recent letter to the state of South Dakota. Your letter seeks "to make arrangements for the return to the FDA of any foreign-manufactured thiopental in [its] possession" based on the recent decision of the federal court for the District of Columbia in *Beaty*.

Beaty is not controlling authority in South Dakota. Since the State of South Dakota was not a party to any court proceedings purporting to determine the legality of its importation of sodium thiopental, and since South Dakota is outside the *Beaty* court's jurisdiction, the State has not had an opportunity to be heard in its defense.

In any event, your concern regarding South Dakota's importation of sodium thiopental is misplaced. I am enclosing the FDA's March 25, 2011, letter authorizing South Dakota's importation of sodium thiopental stock and the accompanying Forms 236. These documents reflect that South Dakota complied with FDA importation processes.

Though South Dakota did not acquire its sodium thiopental from Sandoz or Dream Pharma, the manufacturer and supplier in question in the *Beaty* decision, it nevertheless independently tested its drug. South Dakota's drug tested positive for meeting the United States Pharmacopeia's sodium thiopental standards for safety and efficacy.

To my knowledge, no such testing was performed on the Sandoz/Dream Pharma sodium thiopental at issue in *Beaty*. Such testing may have alleviated the judge's concerns. Testing may have even deprived the *Beaty* plaintiffs of standing to bring their claims in the first place since it was the alleged (but unproven) inefficacy of imported sodium thiopental that allegedly placed them at an increased risk of pain during their executions.

If the FDA would like to independently test a sample of South Dakota's sodium thiopental, the State is certainly willing to accommodate; however, the State must retain legal custody of sufficient amounts of the substance to preserve chain of custody and to assure its safety and efficacy for future use if needed.

As you are aware, the FDA has historically taken the position that drugs "used for the purpose of state-authorized lethal injection clearly fall outside of FDA's explicit public health role." See FDA's December 29, 2010, Sodium Thiopental Statement. Courts have concurred. In a prisoner suit much like *Beaty*, the court in *Delaware v. Deputy*, 644 A.2d 411, 419 (Del. 1994), refused to construe "the FDCA's purpose to include the prevention of lawful executions of inmates."

The *Beaty* decision also conflicts with several federal court decisions. For example, in *Jones v. Hobbes*, 745 F.Supp.2d 886 (E.D.Ark. 2010), several inmates brought claims protesting imported sodium thiopental. The *Jones* court ruled that "Congress committed complete discretion to the executive branch to decide when and how to enforce [the FDCA] and authorized no private right of action for the enforcement of those statutes."

Again in *Durr v. Strickland*, 2010 WL 1610592 (S.D. Ohio), the court held that the FDCA was "not the proper mechanism for seeking injunctive relief from executions." See also *Irick v. Ray*, 2010 WL 4810653 (M.D.Tenn.); *Fruden v. Pillig*, --- F.Supp.2d ---, 2012 WL 292474 (D.Nev.); *West v. Ray*, 2010 WL

3825672 (M.D.Tenn.); *Bowling v. Haas*, 2010 WL 3825467 (E.D.Ky); *State v. Ellis*, 799 N.W.2d 267 (Neb. 2011).

The *Beaty* ruling is also incompatible with several United States Supreme Court decisions. For one, *Beaty* is incompatible with *Brewer v. Landrigan*, --- U.S. ---, 131 S.Ct. 445 (2010), because it speculates that imported sodium thiopental is ineffective. While it is true that the FDA, as a general rule, excludes some foreign drugs because of efficacy questions, such generality does not supply proof of a risk of harm when a particular drug is in question. *Landrigan*, 131 S.Ct. at 445. *Landrigan* prohibits speculating that a drug is unsafe or ineffective simply based on its foreign origins. Because the *Beaty* court had no evidence that the Sandoz/Dream Pharma sodium thiopental at issue was unsafe, the court could not simply speculate that the drug "increased [the plaintiffs'] risk of harm" without running afoul of *Landrigan*. *Beaty*, 2012 WL 1021048 at *4.

Beaty is incompatible with *Baze v. Rees*, 553 U.S. 35, 49, 128 S.Ct. 1520, 1531 (2008), because it creates a means to challenge drugs used in one's execution based simply on a "'relatively modest' increment of risk" of harm, whereas *Baze* requires that no method of execution may be challenged unless an inmate alleges that he faces a "substantial risk" of "serious pain." *Compare Beaty*, 2012 WL 1021048 at *4 *with Baze*, 553 U.S. at 49, 128 S.Ct. at 1531. *Beaty's* relaxed standards are incompatible with *Baze*.

Beaty is also incompatible with the *Heckler* decision because it permits inmates to bring actions to "restrain violations." *Heckler v. Chaney*, 470 U.S. 821, 105 S.Ct. 1649 (1985). The FDCA expressly reserves such authority to suits brought by the government. 21 U.S.C. § 337. According to *Heckler*, whether to bring suit under 21 U.S.C. § 337 is vested solely in the FDA's discretion. *Beaty* fails to address, let alone explain, how the federal APA trumps Congress' express will that actions to "restrain [FDCA] violations" be brought only in the name of the government.

The foregoing cases firmly place the *Beaty* decision in a distinct and singular minority of one. Yet, the FDA would impose the *Beaty* decision on South Dakota when higher courts have approved the FDA's enforcement and importation practices?

The United States Supreme Court has made it abundantly clear that "the decision that capital punishment may be the appropriate sanction in extreme cases is an expression of the community's belief that certain crimes are themselves so grievous an affront to humanity that the only adequate response may be the penalty of death." *See Gregg v. Georgia*, 428 U.S. 153, 184 (U.S. 1976).

One such grievous offender is Donald Eugene Moeller, who raped, sodomized, and stabbed to death a 9 year-old little girl 22 years ago. Two separate juries of South Dakota citizens sentenced Moeller to death for his crimes. Twenty-two years for a victim's family to await justice is disturbing, particularly in light of Congress' clear direction to the Department of Justice in the 2006 AEDPA amendments to establish the rules for state death penalty certification procedures, a responsibility that appears to have gone unfulfilled.

Furthermore, were the FDA to initiate forfeiture proceedings against departments of corrections, it would be selectively enforcing the law because hundreds of hospitals are in possession of imported sodium thiopental. To evenhandedly enforce the law, the FDA must bring forfeiture proceedings against anyone possessing imported sodium thiopental, hospitals included.

As the American Society of Anesthesiologists has informed the FDA, death penalty abolitionists have, through such tactics as the *Beaty* lawsuit, attacked the sodium thiopental supply chain "to the point that the safety of American patients is now in jeopardy." See ASA January 7, 2011, letter, copy attached. In short, if the FDCA mandated you to interdict and confiscate all imported sodium thiopental, innocent patients who require sodium thiopental would be placed at risk.

Finally, there is presently no urgent need to confiscate South Dakota's sodium thiopental justifying an *ex parte* proceeding of any nature because no executions using sodium thiopental are presently scheduled. South Dakota is not willing to forfeit State property without proper notice and opportunity to be heard before a South Dakota court, and before an appellate court if necessary, unless and until we have a satisfactory replacement inventory.

In conclusion, my office will gladly provide you with any information you request regarding the source, purity, or efficacy of the State's sodium thiopental inventory. We will further agree to notify you in the unlikely event that the State would need to utilize its sodium thiopental inventory for an execution before it expires in September of 2012. However, the State must keep its sodium thiopental inventory in its current temperature- and humidity-controlled environment to preserve State property.

Please feel free to contact either myself or Assistant Attorney General Paul Swedlund in my office to discuss how we may address any further concerns that you may have.

Sincerely,

Marty J. Jackley
ATTORNEY GENERAL

MJJ/lde
Enc.

cc: South Dakota Governor Dennis Daugaard
United States Attorney Brendan Johnson
Secretary Dennis Kaemingk, Department of Corrections
Warden Douglas Weber

ERM A.12(B) Capital Punishment Final Days Procedures

A. GENERAL

1. The punishment of death shall be inflicted within the walls of a building at the State Penitentiary. SDCL §23A-27A-32, 23A-27A-33. The South Dakota State Penitentiary (hereinafter SDSP) shall provide all proper equipment and appliances for the infliction of such punishment. SDCL §23A-27A-32, 23A-27A-33. The necessary setup includes a room, hereinafter referred to as the "Chemical Room," equipped with a one-way mirror that allows occupants to observe the Execution Chamber and the inmate after he is strapped to a gurney in the execution chamber.

2. Death shall be inflicted by administering intravenous injections of a substance or substances in a lethal quantity. The substance or substances and manner of execution shall be and remain consistent with state and federal constitutional requirements as identified herein.

3. The Warden or designee is responsible for having the chemicals for lethal injection and any other necessary items for use on the scheduled date of execution. Under the direction of the Warden or designee two complete sets of the substance or substances used to conduct an execution shall be kept in separate secure locations.

4. The Warden shall arrange for the attendance of South Dakota Department of Corrections (hereinafter SDDOC) staff, law enforcement officers and other persons he/she deems necessary and proper to perform the functions involved in conducting a scheduled execution. This shall include all those required by South Dakota statute to attend.

5. If at any time during the execution process the Governor stays, pardons, or commutes the sentence of the condemned person or if a court of competent jurisdiction issues a stay after an execution has commenced, the execution team shall stop the execution. Ambulance staff equipped with advanced life support capabilities, including a heart defibrillator and such supplies and equipment as would be needed to attempt to revive an individual who has been injected with one or more of the substances identified in Section D, shall be on standby at the SDSP.

B. QUALIFICATIONS OF EXECUTION TEAM MEMBERS

1. An execution carried out by intravenous injection shall be performed by person(s) trained to perform venipuncture and to administer intravenous injections. The person(s) shall be selected by the Warden and approved by the Secretary of Corrections. SDCL 23A-27A-32.

2. The person(s) selected by the Warden to mix the drugs and prepare the syringes shall demonstrate proficiency through relevant training and two years' experience in the preparation of syringes for intravenous administration and mixing and preparation of drugs for such administration.

3. The person(s) selected by the Warden to insert the intravenous needles into the veins of the prisoner and connect, monitor, and maintain intravenous lines shall be certified or licensed and have at least two (2) years' professional experience as one of the following: medical or osteopathic physician, physician assistant, registered nurse, certified medical assistant, licensed practical nurse, phlebotomist, paramedic, emergency medical technician, or military corpsman.

4. The person(s) selected by the Warden to administer the injections shall demonstrate proficiency through relevant training and two years' experience in the administration of drugs by intravenous injection.

C. PREPARATION OF CHEMICALS

1. The following identifies the contents of each syringe used in the course of the 3-Drug or 2-Drug executions.

SYRINGE LABELED/MARKED	CONTENTS
#1	Sodium Thiopental (1.5 grams in a 60 cc solution) or Pentobarbital (2.5 grams in a 50 cc solution)
#2	Sodium Thiopental (1.5 grams in a 60 cc solution provided Syringe #1 is also 1.5 grams of Sodium Thiopental in a 60 cc solution) or Pentobarbital (2.5 grams in a 50 cc solution provided Syringe #1 is also 2.5 grams of Pentobarbital in a 50 cc solution)
#3	Normal Saline (25 ml)
#4	Pancuronium Bromide (100 mg of 2 mg/ml concentration in a 50 cc solution)
#5	Normal Saline (25 ml)
#6	Potassium Chloride (120 mEq. in a 60 cc solution)
#7	Potassium Chloride (120 mEq. in a 60 cc solution)
Backup syringes (if needed):	
#8	Normal Saline (25 ml)
#9	Sodium Thiopental (1.5 grams in a 60 cc solution) or Pentobarbital (2.5 grams in a 50 cc solution)
#10	Sodium Thiopental (1.5 grams in a 60 cc solution provided Syringe #1 is also 1.5 grams of Sodium Thiopental in a 60 cc solution) or Pentobarbital (2.5 grams in a 50 cc solution provided Syringe #1 is also 2.5 grams of Pentobarbital in a 50 cc solution)
#11	Normal Saline (25 ml)
#12	Pancuronium Bromide (100 mg of 2 mg/ml concentration in a 50 cc solution)
#13	Normal Saline (25 ml)
#14	Potassium Chloride (120 mEq. in a 60 cc solution)
#15	Potassium Chloride (120 mEq. in a 60 cc solution)

2. The following identifies the contents of each syringe used in the course of the 1-Drug execution using Sodium Thiopental.

SYRINGE LABELED/MARKED	CONTENTS
#1	Sodium Thiopental (1.25 grams in a 50 cc solution)
#2	Sodium Thiopental (1.25 grams in a 50 cc solution)
#3	Sodium Thiopental (1.25 grams in a 50 cc solution)
#4	Sodium Thiopental (1.25 grams in a 50 cc solution)
#5	Normal Saline (25 ml)
Backup syringes (if needed):	
#6	Sodium Thiopental (1.25 grams in a 50 cc solution)
#7	Sodium Thiopental (1.25 grams in a 50 cc solution)
#8	Sodium Thiopental (1.25 grams in a 50 cc solution)
#9	Sodium Thiopental (1.25 grams in a 50 cc solution)

3. The following identifies the contents of each syringe used in the course of the 1-Drug execution using Pentobarbital.

SYRINGE LABELED/MARKED	CONTENTS
#1	Pentobarbital (2.5 grams in a 50 cc solution)
#2	Pentobarbital (2.5 grams in a 50 cc solution)
#3	Normal Saline (25 ml)
Backup syringes (if needed):	
#4	Pentobarbital (2.5 grams in a 50 cc solution)
#5	Pentobarbital (2.5 grams in a 50 cc solution)

4. Any person sentenced to death prior to July 1, 2007, may choose to be executed by the 3- or 1-Drug protocol set forth in this document, provided the SDDOC possesses the necessary substance or substances for the method chosen at the time scheduled for the inmate's execution, or in the manner provided by South Dakota law at the time of the person's conviction (2-Drug protocol set forth in this document). Any person sentenced to death prior to July 1, 2007, shall be executed using the 3- or 1-Drug protocol provided in this document using the substance or substances in the SDDOC's possession unless the inmate requests in writing to the Warden not less than seven (7) days prior to the scheduled execution date that the inmate wishes to be executed by the 2-Drug protocol set forth herein in accordance with South Dakota law as it existed prior to July 1, 2007.

5. For any inmate sentenced to death after July 1, 2007, the Warden shall elect the method of execution from one of the foregoing 3-, 2-, or 1-Drug methods for which the SDDOC possesses the necessary substance or substances at the time scheduled for the inmate's execution. The Warden will give consideration to, and make the effort to accommodate, the inmate's method of preference, provided the inmate selects 3-, 2-, or 1-Drug methods for which the SDDOC possesses the necessary substance or substances at the time scheduled for the inmate's execution.

D. PREPARATION FOR EXECUTION

1. The SDDOC staff selected to participate in the execution shall drill at least weekly for six to eight weeks prior to the scheduled date of execution. The warden shall schedule additional drills the week of the scheduled execution.

2. Not less than seven (7) days prior to the execution week announced in the Warrant of Death Sentence and Execution, a physician or other medical professional qualified to assess venous access shall examine the inmate. A written report shall be prepared describing the inmate's physical condition and any medical condition of the inmate that may lead to potential problems establishing an IV site. This report, along with a copy of the lethal injection protocol, shall be provided to the executioner(s) for review and consideration no later than one day before the scheduled date of execution.

3. All substances will be mixed or prepared as necessary no more than 8 hours prior to the execution and shall thereafter be maintained in accordance with manufacturers' instructions in temperatures not in excess of 22°C/71.6°F, or such temperature specifically called for by the manufacturer, until ready for use. All substances will be mixed or prepared in bright, un-dimmed light.

4. To provide notification of any last minute stay or appeal, arrangements shall be made to provide direct telephone access between the Warden, the chemical room, the Governor's office, the Chief Justice of the South Dakota Supreme Court or designee, and the Attorney General's office. The Governor, the Chief Justice, and Attorney General or their designees shall be provided with phone numbers to the Warden's office, the chemical room, and multiple backup phone numbers (such as personal cell phone numbers of the Warden and Deputy Warden). In addition, the Warden and Deputy Warden shall be equipped with SDSP issued radios.

5. On the date of the scheduled execution, the prisoner shall be escorted to the execution chamber and strapped to the gurney by the Tie Down Team.

6. On the date of execution, the chemical room shall be kept clear of all persons except for the Executioners, the Warden, and any SDDOC staff selected by the Warden to assist with the execution of the sentence of death.

7. The Tie Down Team Leader shall verify that all restraints are secure and so advise the Warden, at which time the Tie Down Team shall move to the hallway and stand by.

8. The IV team shall enter the chamber and establish two independent IV lines to the inmate's veins. The IV team will establish IV lines only in peripheral veins located in the inmate's arms, hands, legs, or feet, preferably one in each arm. In the event the IV team cannot establish peripheral vein lines, the IV team will establish central vein lines by percutaneous methods, but only if the IV team member establishing the central vein line can demonstrate current training, credentialing, and proficiency in establishing IV lines in central veins by percutaneous methods. The IV team will establish and secure the IV lines in such a way as to leave them visible for monitoring.

9. The gurney shall at all times be placed so that the inmate's head and face are visible to the Warden and to those in the chemical room. If the inmate desires, and if it will not interfere with the efficacy of the substance or substances being used for the execution, the inmate's head will be propped up by a firm, foam wedge-shaped cushion to better permit IV team members in the chemical room to see the inmate's face during the procedure.

10. Every effort will be extended to ensure that no unnecessary pain or suffering is inflicted on the inmate.

11. If the IV team cannot secure one (1) or more sites within one (1) hour, the Governor's Office shall be contacted by the Secretary and a request shall be made that the execution be scheduled for a later date during the week of the execution, as set forth in the Warrant of Death Sentence and Execution.

12. The IV team shall start a saline flow and a sufficient quantity of saline solution shall be injected to confirm that the IV lines have been properly inserted and are not obstructed. IV team members will continue to monitor IV functioning from within the chemical room.

E. INJECTION PROCEDURES---3 DRUG PROTOCOL

1. The Warden shall make a final check with those authorities cited in Section D(4) to ensure no last minute appeals or stays have been filed.

2. Upon completion of preparation for execution (D. above), the Warden or designee shall order that blinds in front of witness rooms be opened and that the microphone in front of the inmate's mouth be turned on. The Warden or designee shall ask the prisoner if he/she has any last words to say. Upon completion of the prisoner's last words, or in the discretion of the Warden, the Warden shall order that the execution proceed.

3. Upon the Warden's order to proceed, a designated team member will begin a rapid flow of lethal chemicals in the following order.

4. Syringe #1

5. Syringe #2

6. Syringe #3

7. If it appears to the Warden that the prisoner is not unconscious within three (3) minutes after administration of the sodium thiopental or pentobarbital, the Warden shall order the flow of chemicals ceased into the primary site. The backup IV shall be used with a new flow of sodium thiopental or pentobarbital.

8. The Warden and IV team shall assess and monitor the inmate's lack of consciousness by using all steps in a graded consciousness check – a sequence of increasingly strong stimulations to assess consciousness – starting with checking for movement, eyelash reflex, response to verbal commands and culminating in a physical stimulation that would be painful if the inmate were awake. If possible, a currently certified EMT or other medical professional qualified in assessing consciousness, whose identity may, at the Warden's discretion, remain confidential, will be in the execution chamber with the Warden to assist the Warden in determining that the inmate is unconscious following the injection of the sodium thiopental or pentobarbital and prior to the administration of the pancuronium bromide and potassium chloride.

9. The Warden and IV team shall continuously monitor the IV and infusion sites. If the inmate appears unconscious three (3) minutes after the initial or backup flow of sodium thiopental or pentobarbital is complete, the executioner(s) shall commence the rapid flow of the remaining chemicals as follows.

10. Syringe #4

11. Syringe #5

12. Syringe #6

13. Syringe #7

14. Ten (10) minutes after the third drug is administered, the person(s) responsible for pronouncing death shall examine the inmate in order to confirm death by checking the inmate's heartbeat, breathing, pulse and pupils. If the inmate's death is confirmed, the person(s) shall inform the Warden. If that person(s) is unable to confirm the inmate's death, the Warden shall order injection of the remaining backup syringes.

15. Once the person(s) responsible for pronouncing death has confirmed the inmate's death, the Warden shall announce "At approximately _____ a.m./p.m. the execution of [inmate's name] was carried out in accordance with the laws of the State of South Dakota" or a similar statement to that effect.

16. The microphone shall be turnned off and the curtains/blinds shall be drawn.

17. The witnesses shall be escorted out of the witness rooms and shall sign the Certificate of Execution as required by South Dakota law.

F. INJECTION PROCEDURES—2 DRUG PROTOCOL

1. The Warden shall make a final check with those authorities cited in Section D(4) to ensure no last minute appeals or stays have been filed.

2. Upon completion of preparation for execution (D. above), the Warden or designee shall order that blinds in front of witness rooms be opened and that the microphone in front of the inmate's mouth be turned on. The Warden or designee shall ask the prisoner if he/she has any last words to say. Upon completion of the prisoner's last words, or in the discretion of the Warden, the Warden shall order that the execution proceed.

3. Upon the Warden's order to proceed, a designated team member will begin a rapid flow of lethal chemicals in the following order.

4. Syringe #1

5. Syringe #2

6. Syringe #3

7. If it appears to the Warden that the prisoner is not unconscious within three (3) minutes after administration of the sodium thiopental or pentobarbital the Warden shall order the flow of chemicals ceased into the primary site. The backup IV shall be used with a new flow of sodium thiopental or pentobarbital.

8. The Warden and IV team shall assess and monitor the inmate's lack of consciousness by using all steps in a graded consciousness check – a sequence of increasingly strong stimulations to assess consciousness – starting with checking for movement, eyelash reflex, response to verbal commands and culminating in a physical stimulation that would be painful if the inmate were awake. If possible, a currently certified EMT or other medical professional qualified in assessing consciousness, whose identity may, at the Warden's discretion, remain confidential, will be in the execution chamber with the Warden to assist the Warden in determining that the inmate is unconscious following the injection of the sodium thiopental or pentobarbital and prior to the administration of the pancuronium bromide and potassium chloride.

9. The Warden and IV team shall continuously monitor the IV and infusion sites. If the inmate appears unconscious three (3) minutes after the initial or backup flow of sodium thiopental or pentobarbital is complete, the executioner(s) shall commence the rapid flow of the remaining chemicals as follows.

10. Syringe #4

11. Syringe #5

12. Ten (10) minutes after the second drug is administered, the person(s) responsible for pronouncing death shall examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils. If that person(s) is not able to pronounce death, the Warden shall order injection of the remaining backup syringes.

13. Once the person(s) responsible for pronouncing death has confirmed the inmate's death, the Warden shall announce "At approximately _____ a.m./p.m. the execution of [inmate's name] was carried out in accordance with the laws of the State of South Dakota" or a similar statement to that effect.

14. The microphone shall be turned off and the curtains/blinds shall be drawn.

15. The witnesses shall be escorted out of the witness rooms and shall sign the Certificate of Execution as required by South Dakota law.

G. INJECTION PROCEDURES – 1 DRUG PROTOCOL (Sodium Thiopental)

1. The Warden shall make a final check with those authorities cited in Section D(4) to ensure no last minute appeals or stays have been filed.

2. Upon completion of preparation for execution (D. above), the Warden or designee shall order that blinds in front of witness rooms be opened and that the microphone in front of the inmate's mouth be turned on. The Warden or designee shall ask the prisoner if he/she has any last words to say. Upon completion of the prisoner's last words, or in the discretion of the Warden, the Warden shall order that the execution proceed.

3. Upon the Warden's order to proceed, a designated team member will begin a rapid flow of lethal chemicals in the following order.

4. Syringe #1

5. Syringe #2

6. Syringe #3

7. Syringe #4

8. Syringe #5

9. Ten (10) minutes after the drug is administered, the person(s) responsible for pronouncing death shall examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils. If that person(s) is not able to pronounce death, the Warden shall order a second set of chemicals to be administered in the following order.

10. Syringe #6

11. Syringe #7

12. Syringe #8

13. Syringe #9

14. Ten (10) minutes after the second round of the drug is administered, the person(s) responsible for pronouncing death shall again examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils.

15. Once the person(s) responsible for pronouncing death has confirmed the inmate's death, the Warden shall announce "At approximately _____ a.m./p.m. the execution of [inmate's name] was carried out in accordance with the laws of the State of South Dakota" or a similar statement to that effect.

16. The microphone shall be turned off and the curtains/blinds shall be drawn.

The witnesses shall be escorted out of the witness rooms and shall sign the Certificate of Execution as required by South Dakota law.

H. INJECTION PROCEDURES – 1 DRUG PROTOCOL (Pentobarbital)

1. The Warden shall make a final check with those authorities cited in Section D(4) to ensure no last minute appeals or stays have been filed.

2. Upon completion of preparation for execution (D. above), the Warden or designee shall order that blinds in front of witness rooms be opened and that the microphone in front of the inmate's mouth be turned on. The Warden or designee shall ask the prisoner if he/she has any last words to say. Upon completion of the prisoner's last words, or in the discretion of the Warden, the Warden shall order that the execution proceed.

3. Upon the Warden's order to proceed, a designated team member will begin a rapid flow of lethal chemicals in the following order.

4. Syringe #1

5. Syringe #2

6. Syringe #3

7. Ten (10) minutes after the drug is administered, the person(s) responsible for pronouncing death shall examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils. If that person(s) is not able to pronounce death, the Warden shall order a second set of chemicals to be administered in the following order.

8. Syringe #4

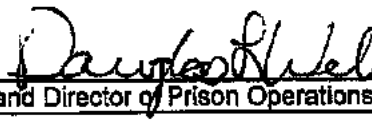
9. Syringe #5

10. Ten (10) minutes after the second round of the drug is administered, the person(s) responsible for pronouncing death shall again examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils.

11. Once the person(s) responsible for pronouncing death has confirmed the inmate's death, the Warden shall announce "At approximately _____ a.m./p.m. the execution of [inmate's name] was carried out in accordance with the laws of the State of South Dakota" or a similar statement to that effect.

12. The microphone shall be turned off and the curtains/blinds shall be drawn.

The witnesses shall be escorted out of the witness rooms and shall sign the Certificate of Execution as required by South Dakota law.

Douglas L. Weber 	October 13, 2011
Douglas L. Weber, Chief Warden and Director of Prison Operations	Date

SUPREME COURT
STATE OF SOUTH DAKOTA
FILED
NOV - 1 2019
Clerk

IN THE SUPREME COURT
STATE OF SOUTH DAKOTA

CHARLES RUSSELL RHINES,

Plaintiff/Appellant,

v.

SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, Secretary, South Dakota Department Of Corrections, and **DARIN YOUNG,** Warden, South Dakota State Penitentiary,

Defendants/Appellees.

No. 29166

RESPONSE TO MOTION FOR STAY OF EXECUTION

Appellee Darin Young, by and through his counsel, Paul S. Swedlund, hereby files this response to appellant Charles Russell Rhines' motion for a stay of execution.

1. Charles Russell Rhines killed Donnivan Schaeffer in 1992 and was sentenced to death in 1993. Donnivan's parents and brother have awaited justice for their son and sibling for 27 years.
2. This court affirmed Rhines' conviction in 1996. *State v. Rhines*, 548 N.W.2d 415 (1996).
3. The United States Supreme Court denied Rhines' petition for a writ of *certiorari* to review this court's affirmance. *Rhines v. South Dakota*, 117 S.Ct. 522 (1996).

4. Rhines filed his first state *habeas corpus* petition in 1996. The state court denied the petition in 1998. This court affirmed the trial court's denial in 2000. *Rhines v. Weber,* 2000 SD 19, 608 N.W.2d 303.

5. Rhines filed a federal *habeas corpus* petition in 2000. As a result of that proceeding, the United States Supreme Court ruled that federal review of Rhines' first state *habeas corpus* claims would be "stayed and abeyed" while he exhausted a new set of claims in a second state *habeas corpus* proceeding. *Rhines v. Weber,* 544 U.S. 269 (2005).

6. Rhines filed an amended second state *habeas corpus* petition in 2005. The state court entered summary judgment denying the petition in 2012.

7. In concert with his second state *habeas corpus* petition, Rhines also challenged the constitutionality of the state's execution protocol. After a trial in which the court took testimony and evidence from both parties, the state court entered judgment in favor of the state.

8. This court affirmed the denial of Rhines' second state *habeas corpus* petition and the judgment rejecting his method of execution challenge. *Rhines v. Weber,* #26673 (S.D. 2013).

9. The United States Supreme Court denied Rhines' petition for a writ of *certiorari* to review this court's decision. *Rhines v. Weber,* 134 S.Ct. 1002 (2014).

10. Rhines reactivated his pending federal *habeas corpus* petition for review of the first and second state *habeas corpus* decisions. Rhines also moved to amend his federal petition to bring new claims of alleged neurological deficits per *Martinez v. Ryan*, 566 U.S. 1 (2012). The district court denied the petition and the *Martinez* motion in 2016. *Rhines v. Young*, 2016 WL 615421 (D.Ct.S.D.)

11. Rhines filed an original action in this court to set aside his sentence on the grounds of alleged jury bias per *Pena-Rodriguez v. Colorado*, 137 S.Ct. 855 (2017). This court rejected the application. *Rhines v. South Dakota*, #28444 (S.D. 2018).

12. The United States Supreme Court denied Rhines' petition for a writ of *certiorari* to review this court's rejection of his *Pena-Rodriguez* application. *Rhines v. South Dakota*, 138 S.Ct. 2660 (2018).

13. Rhines appealed the district court's denials of his *habeas corpus* petition and *Martinez* motion. Rhines also asked the circuit court for a certificate to appeal the district court's denial of a motion to amend his petition to bring the same *Pena-Rodriguez* claim rejected by this court. The circuit court affirmed the district court's judgment in the *habeas corpus* case and denied Rhines' application for a certificate to appeal the *Pena-Rodriguez* issue. *Rhines v. Young*, 899 F.3d 482 (8th Cir. 2018). Rhines petitioned the United States Supreme Court for review of these rulings.

14. While Rhines' petitions for *certiorari* were pending, he filed a petition for clemency with the South Dakota Board of Pardons and Paroles. The board rejected Rhines' petition.

15. On April 15, 2019, the United States Supreme Court denied Rhines' petitions to appeal the circuit court's rulings affirming the district court's denial of *habeas corpus* relief and denying Rhines a certificate to appeal his *Pena-Rodriguez* claim. *Rhines v. Young*, 2019 WL 826425; *Rhines v. Young*, 2019 WL 826426.

16. With the United States Supreme Court's rejection of Rhines' latest petitions, Rhines' conviction and sentence became final. It is time for Rhines to serve his sentence.

17. Rhines also appealed the denial of a motion filed in the district court (two years after it denied his *habeas corpus* petition) seeking an order compelling the South Dakota Department of Corrections to allow new experts to examine Rhines in the penitentiary to develop evidence of a previously undetected neurological deficit to bolster a second clemency petition. That case was argued to the federal appellate court on September 26, 2019. The court dismissed the appeal on October 25, 2019.

18. In September of 2018, Rhines filed a complaint for declaratory and injunctive relief in circuit court claiming that the state's execution protocol was invalid because it had not been promulgated pursuant to

the state APA. The circuit court denied relief. This court affirmed the circuit court on October 25, 2019. *Rhines v. S.D. Dept. of Corrections*, 2019 SD 59.

19. On October 22, 2019, Rhines filed a complaint for declaratory and injunctive relief claiming that the state's intention to use pentobarbital as the barbiturate in his execution violated SDCL 23A-27A-32 as codified on the date of his conviction. Rhines filed a motion for a preliminary injunction and stay of his execution. The circuit court held an expedited evidentiary hearing on the motion on October 29, 2019. It issued its ruling on October 31, 2019, denying the motion on the ground that Rhines' claim was barred on principles of *res judicata* and equity because could have brought his claims much earlier. Rhines now appeals.

20. Rhines' appeal in the above captioned matter is without merit. No stay is warranted because Rhines is not likely to succeed in overturning Judge Sogn's detailed and well-reasoned opinion.

21. Recently, in *Bucklew v. Precythe*, 139 S.Ct. 1112, 1134 (2019), the United States Supreme Court condemned the practice of reflexively entering stays of execution. Stays of execution "should be the extreme exception, not the norm." *Bucklew*, 139 S.Ct. at 1134. Per *Bucklew*, no stay should be entered for lawsuits that attack settled precedent, which rest on speculative theories, which lack sufficient substance to survive summary judgment and which could have been brought sooner. *Bucklew*, 139 S.Ct. at 1134.

22. *Bucklew* reaffirmed the longstanding principle that the mere fact that an inmate has filed some kind of claim – even a potentially meritorious one – "does not warrant the entry of a stay as a matter of right." *Nelson v. Campbell,* 541 U.S. 637, 649 (2004). *McFarland v. Scott,* 512 U.S. 849, 858 (filing for post-conviction relief "by no means grants capital defendants a right to an automatic stay of execution"). "[I]f a dilatory capital defendant inexcusably ignores [the] opportunity [to bring a claim earlier] and flouts the available processes, a . . . court presumably would not abuse its discretion in denying a stay of execution." *McFarland,* 512 U.S. at 858.

23. "Given the state's significant interest in enforcing its criminal judgments, there is a strong equitable presumption against the grant of a stay where a claim could have been brought at such a time as to allow consideration of the merits without requiring entry of a stay." *Nelson,* 541 U.S. at 650. "[A] plaintiff cannot wait until a stay must be granted to enable him to develop facts and take the case to trial – not when there is no satisfactory explanation for the delay." *Sepulvado v. Jindal,* 729 F.3d 413, 420 (5th Cir. 2013), quoting *Reese v. Livingston,* 453 F.3d 289, 291 (5th Cir. 2006). A prisoner is not entitled to a stay in order to conduct discovery to make out a claim. *Beaty v. Brewer,* 649 F.3d 1071, 1075 (9th Cir. 2011).

24. "[A] stay of execution is an equitable remedy. It is not available as a matter of right, and equity must be sensitive to the state's strong interest in enforcing its criminal judgments." *Hill v. McDonough,* 547 U.S. 573, 584 (2006). A "preliminary injunction [for a stay of execution is] *not* granted unless the movant, by a clear showing, carries the burden of persuasion." *Hill,* 547 U.S. at 584.

25. "[L]ike other stay applicants, [Rhines] . . . must satisfy all of the requirements for a stay including a showing of a significant possibility of success on the merits." *Hill,* 547 U.S. at 584.

26. No stay is warranted by the above-captioned appeal. Rhines was extremely dilatory in bringing his challenge to the protocol's conformity to the statute. As described in Judge Sogn's ruling, the factual basis for Rhines' claim was known to him when the state served him with the current protocol on October 24, 2011. He could have challenged this aspect of the protocol as early as 2011 when he challenged the constitutionality of the method of execution in his second state *habeas corpus* proceeding before Judge Trimble in 2011-12. He did not. Instead, Rhines waited until 11 days before the week scheduled for his execution to bring the claim. Rhines' failure to act sooner demonstrates how the claim and this appeal were a calculated "tool to interpose unjustified delay." *Bucklew,* 139 S.Ct. at 1134.

27. Rhines is now well beyond his due process. His objections to his conviction and sentence and method of execution have been reviewed five times by this court, five by the United States Supreme Court, twice by the federal circuit court of appeals and once by the federal district court. In December of 2018, he petitioned for and was denied clemency by the South Dakota Board of Pardons and Paroles. Having exhausted his *due* process, Rhines has turned to extraneous processes "to interpose unjustified delay" in the imposition of his sentence. *Bucklew*, 139 S.Ct. at 1134.

CONCLUSION

Twenty-seven years ago Rhines walked young Donnivan Schaeffer to his death in a dingy storeroom of a strip-mall donut shop, where Rhines sat Donnivan on the floor, locked his head between his knees and pounded a hunting knife into Donnivan's brain stem with the flat of his palm. It is time for Rhines to take the same walk that he blithely took Donnivan on 27 years ago.

The state's method of execution has been vetted at the highest levels of the executive and judicial branches of state government. It has been followed in four prior executions (Page, Robert, Moeller, Berget) without any report of mishap or maladministration. Rhines strategically waited until the eve of his execution to challenge the barbiturate the state told him it intended to use 8 years ago.

A cursory review of Judge Sogn's opinion reveals that Rhines' appeal is not sufficiently meritorious to warrant a stay. Per *Buckley*, this court "'can and should' protect" the state's interest in carrying out Rhine's capital sentence "from 'undue interference'" by denying a stay. *Buckley*, 139 S.Ct. at 1134.

Dated this 1st day of November 2019.

Respectfully submitted,

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CERTIFICATE OF SERVICE

Appellees, by and through their counsel, Paul S. Swedlund, hereby certify that on November 1, 2019, a copy of the foregoing response to motion for stay was served on appellant's counsel, Daniel R. Fritz and Timothy R. Rahn, via e-mail to fritzd@ballardspahr.com and rahnt@ballardspahr.com and Caroline Heller at hellerc@gtlaw.com.

Paul S. Swedlund
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Assistant Attorney General

CAPITAL CASE: APPELLANT SCHEDULED FOR EXECUTION WEEK OF NOVEMBER 3-9, 2019

IN THE SUPREME COURT
STATE OF SOUTH DAKOTA

No. 29166

SUPREME COURT
STATE OF SOUTH DAKOTA
FILED
NOV - 1 2019
Clerk

CHARLES RUSSELL RHINES,

Plaintiff and Appellee,

v.

SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, Secretary, South Dakota Department of Corrections, and DARIN YOUNG in his capacity as Warden of the South Dakota State Penitentiary

Defendants and Appellants.

APPEAL FROM THE CIRCUIT COURT
2nd JUDICIAL CIRCUIT
MINNEHAHA COUNTY, SOUTH DAKOTA

THE HONORABLE JOHN C. SOGN
Circuit Court Judge

APPELLEE'S BRIEF

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Notice of Appeal Filed October 31, 2019

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JURISDICTIONAL STATEMENT

This court has jurisdiction pursuant to SDCL 15-26A-3(5).

STATEMENT OF LEGAL ISSUES AND AUTHORITIES

THE TRIAL COURT PROPERLY FOUND THAT RHINES' CLAIMS WERE BARRED BY PRINCIPLES OF *RES JUDICATA?*

Farmer v. South Dakota Dept. of Rev., 2010 SD 35, 781 N.W.2d 655

McGehee v. Hutchinson, 854 F.3d 488 (8th Cir. 2018)

The circuit court ruled that Rhines' claims did not ripen until he received an October 17, 2019, letter from the defendants identifying pentobarbital as the barbiturate that would be used in his execution.

RHINES HAD NO SIGNIFICANT POSSIBILITY OF SUCCEEDING ON THE MERITS OF HIS CLAIMS?

Bucklew v. Precythe, 139 S.Ct. 1112 (2019)

Hill v. McDonough, 547 U.S. 573 (2006)

Glossip v. Gross, 135 S.Ct. 2726 (2015)

Pavatt v. Jones, 627 F.3d 1336 (10th Cir. 2010)

The circuit court ruled that Rhines had demonstrated the requisite criteria for a preliminary injunction, including a likelihood of success on the merits.

SUMMARY OF ARGUMENT

Rhines could have brought this challenge 8 years ago. Instead, he waited until the end of the 11th day before the week scheduled for his execution to raise this issue. The issue is barred by *res judicata* because Rhines could have raised this issue in the method of execution challenge he litigated back in 2011 (or brought a stand-alone claim at any time since).

Also, Rhines cannot succeed on the merits. Rhines' argument rests on the classification of pentobarbital as a short-acting barbiturate

in a low-dosage, clinical setting. Here the drug is not being administered in a low dose in a clinical setting. Comparing the properties of low-dosage sodium thiopental or pentobarbital in a clinical setting with high-dosage pentobarbital in an execution setting is comparing apples to oranges. When used in a high-dosage, execution setting, the properties of pentobarbital are identical to the ultrashort-acting barbiturate sodium thiopental.

STANDARD OF REVIEW

This court does not disturb a ruling on injunctive relief unless it finds an abuse of discretion. *Strong v. Atlas Hydraulics, Inc.*, 2014 SD 69, ¶ 10, 855 N.W.2d 133, 138. This court reviews the trial court's findings of fact under a clearly erroneous standard but it gives no deference to its conclusions of law. *Strong*, 2014 SD 69 at ¶ 10, 855 N.W.2d at 138. This court conducts a *de novo* review of a trial court's ruling on the issue of *res judicata*. *People ex rel. L.S.*, 2006 SD 76, ¶ 21, 721 N.W.2d 83, 89.

ARGUMENT

The trial court properly found that all of Rhines' claims were barred by principles of *res judicata*. In addition, the evidence in the record demonstrates that Rhines had no significant possibility of succeeding on his claims. Accordingly, the trial court did not abuse its discretion in denying Rhines' motion for a stay of execution.

A. Rhines' Claims Are Barred By *Res Judicata*

Eight years ago, Rhines was served with formal notice of the adoption of a revised execution protocol. ERM A.12(B).C.1, Exhibit 1. The protocol designated either sodium thiopental or pentobarbital as the barbiturate to be used in the 2-drug protocol that Rhines has elected. ERM A.12(B).C.1, Exhibit 1. Specifically, it informed Rhines that if he elected the 2-drug protocol, he would "be executed by the 2-drug protocol *set forth herein.*" The protocol specifically informed Rhines that the barbiturate used would be either sodium thiopental or pentobarbital. ERM A.12(B).C.1/4, Exhibit 1. The notice was served on Rhines in the context of a then-pending challenge to his method of execution before Judge Trimble in the 7th Circuit Court.

Rhines filed his challenge on February 21, 2008. FIRST AMENDED PETITION, Exhibit 2. Then, as now, Rhines requested declaratory and injunctive relief. Then, Rhines' complaints were:

a. That 23A-27A-32 "as codified on the date of Charles R. Rhines' convictions" gave "no guidance as to the type of substances used or the quality of substances used for the punishment of death." FIRST AMENDED PETITION at Page 11, ¶¶ 37, 39.a, Exhibit 2.
b. About "the two chemical[s] specified in SDCL 23A-27A-32 in effect at the time [of] Charles R. Rhines' conviction." FIRST AMENDED PETITION at Page 12, ¶ 6, Exhibit 2.

c. That "[a]n execution pursuant to SDCL 23A-27A-32 as codified on the date of Charles R. Rhines' conviction violates the constitutions of the State of South Dakota and the United States prohibition against cruel and unusual punishment and is therefore unconstitutional." FIRST AMENDED PETITION at Page 13, ¶ 7, Exhibit 2.

d. That "a[n] execution carried out by means of the two-drug cocktail provided in SDCL 23A-27A-32 in effect at the time of Charles R. Rhines' conviction constitutes cruel and unusual punishment in violation of the constitution of the State of South Dakota and the United States as well as depriving Rhines of his right to *due process* of law." FIRST AMENDED PETITION at Page 13, ¶ 3, Exhibit 2 (emphasis added).

Though he had been served with a copy of ERM A.12(B) on October 24, 2011, which contained explicit notice of the state's intention to use pentobarbital in the 2-drug protocol that Rhines has elected, and though Rhines' then-pending complaint for declaratory and injunctive relief contained general arguments that ERM A.12(B).C.1 denied him process that he felt was due to him under SDCL 23A-27A-32 and in opposition to the "two chemical[s]" that would be used, Rhines never raised a claim that pentobarbital is not an ultrashort-acting barbiturate within the meaning of SDCL 23A-27A-32 as codified on the date of his convictions.

During the litigation of Rhines' method of execution claims, the state had its expert opine on whether a 2-drug protocol of pentobarbital

and a paralytic agent would provide a painless and humane death for an inmate. DERSHWITZ TESTIMONY at 21/22, excerpt attached as Exhibit 3. In addition to the ERM A.12(B).C.1. itself, this questioning put Rhines on further notice of the state's intent to use pentobarbital in carrying out the 2-drug protocol that he has chosen.

Judge Trimble ruled against Rhines. TRIMBLE DECISION, Exhibit 4. The South Dakota Supreme Court affirmed. AFFIRMANCE ORDER, Exhibit 5.

During Rhines' subsequent federal proceedings, the state expected Rhines to amend his complaint to further challenge the state's method of execution in federal court. The state moved peremptorily to dismiss the claim (along with all of Rhines' other pending claims) anticipating that Rhines would continue his method of execution challenge. Remarkably, Rhines did not do so. Instead Rhines inexplicably threw in the towel on further challenging the method of his execution, brusquely stating that "the issue of the manner of execution, which was included in the latest litigation in the state court, and which was discussed at such length in respondent's brief, is not before this court and this court cannot issue any sort of judgment concerning that issue." RHINES RESPONSE TO FEDERAL MOTION FOR SUMMARY JUDGMENT, CIV # 00-5020 [DOCKET 232] at 6, excerpt attached as Exhibit 6.

"The doctrine of *res judicata* disallows reconsidering an issue that was actually litigated or which *could have been* raised and decided in a

prior action. *Farmer v. South Dakota Dept. of Rev.,* 2010 SD 35, ¶7, 781 N.W.2d 655, 659. The factual predicate for Rhines' theory that pentobarbital is not an ultrashort-acting barbiturate existed 8 years ago and fell under the umbrella of challenges to the statute and the process allegedly due him under state law contained in the complaint for declaratory and injunctive relief. Because Rhines certainly could have brought a specific challenge to the use of pentobarbital to carry out the 2-drug protocol as part of his then-pending complaint for declaratory and injunctive relief 8 years ago, his current claims, and dependent claim for equitable injunction, are firmly barred by principles of *res judicata.*

B. Rhines Did Not Present Clear Evidence Of A Significant Possibility Of Prevailing On The Merits

Recently, in *Bucklew v. Precythe,* 139 S.Ct. 1112, 1134 (2019), the United States Supreme Court condemned the practice of reflexively entering stays of execution. Stays of execution "should be the extreme exception, not the norm." *Bucklew,* 139 S.Ct. at 1134. *Bucklew* reaffirmed the longstanding principle that the mere fact that an inmate has filed some claim for relief – even a potentially meritorious one – "does not warrant the entry of a stay as a matter of right." *Nelson v. Campbell,* 541 U.S. 637, 649 (2004).

"[A] stay of execution is an equitable remedy. It is not available as a matter of right, and equity must be sensitive to the state's strong interest in enforcing its criminal judgments." *Hill v. McDonough,* 547 U.S. 573, 584 (2006). Before a court grants a stay, it must consider "the

relative harms to the parties," "the likelihood of success on the merits," and "the extent to which the inmate has delayed in bringing the claim." *Nelson,* 541 U.S. at 649-50. A "preliminary injunction [for a stay of execution is] *not* granted unless the movant, by a clear showing, carries the burden of persuasion." *Hill,* 547 U.S. at 584. Rhines has not carried his burden with clear evidence that the relative harms weigh in his favor, that he is likely to succeed on the merits and that he has not been purposefully and strategically dilatory in bringing his claim.

i. Relative Harms

A court considers the relative harms to the parties by balancing the competing interests of Rhines and South Dakota; specifically, Rhines' interest in being executed with sodium thiopental versus pentobarbital. *Ledford v. Georgia Dept. of Corr.,* 856 F.3d 1312, 1315 (11th Cir. 2017). "A defendant's interest in being free from cruel and unusual punishment is primary; however, a state's interest in effectuating its judgment remains significant." *McNair v. Allen,* 515 F.3d 1168, 1172 (11th Cir. 2008). Victims of crime also "have an important interest in the timely enforcement of a sentence." *Hill,* 547 U.S. at 584.

As detailed below, courts have uniformly found that sodium thiopental and pentobarbital perform exactly the same and that substituting pentobarbital for sodium thiopental does not materially alter an execution protocol. Given that there is no difference between the two drugs when administered in an execution setting, Rhines' interest in

being executed with sodium thiopental instead of pentobarbital is far outweighed by the state's interest in effecting its judgment and the victims' interest in justice (after 27 years) for their murdered son. *Ledford,* 856 F.3d at 1315.

ii. Likelihood Of Success On The Merits

"[L]ike other stay applicants, inmates seeking time to challenge the manner in which the state plans to execute them must satisfy all of the requirements for a stay including a showing of a significant possibility of success on the merits." *Hill,* 547 U.S. at 584. Rhines cannot demonstrate a significant probability of success on the merits because his claim is barred by *res judicata* and because pentobarbital meets the classification of an ultrashort-acting barbiturate in an execution setting.

Just as "[a] time-barred complaint cannot justify a stay of execution, regardless of whether its claims have merit," a claim barred by *res judicata* will not justify a stay of execution, even if it may have had merit had it been timely litigated. *Gissendaner v. Georgia Dept. of Corr.,* 779 F.3d 1275, 1284 (11th Cir. 2015); *Ledford,* 856 F.3d at 1315. Because Rhines' complaint is barred by *res judicata,* he cannot show a substantial likelihood of success on the merits and a stay of execution is not warranted. *Ledford,* 856 F.3d at 1316.

Nor is there a "significant possibility" that Rhines can succeed in proving that pentobarbital does not meet the classification of an

ultrashort-acting barbiturate as contemplated by SDCL 23A-27A-32 as codified at the time Rhines was convicted. *Hill,* 547 U.S. at 584.

SDCL 23A-27A-32 does not specify sodium thiopental. It permits the use of any drug that meets the classification of an ultrashort-acting barbiturate. Courts have consistently found that there is no material difference between sodium thiopental and pentobarbital:

a. In *Ringo v. Lombardi,* 677 F.3d 793 (8th Cir. 2012), the court observed that "each court to consider the issue has uniformly held that the use of pentobarbital in lieu of sodium thiopental" is not a material alteration to an execution protocol.

b. In *Powell v. Thomas,* 641 F.3d 1255, 1258 (11th Cir. 2011) the court stated that "[t]he replacement of sodium thiopental with pentobarbital does not constitute a significant alteration in the lethal injection protocol."

c. In *Pavatt v. Jones,* 627 F.3d 1336, 1338 (10th Cir. 2010), the court rejected an 8th Amendment challenge to Oklahoma's lethal injection protocol based on the state's substitution of pentobarbital for sodium thiopental. Though Oklahoma's statute, like South Dakota's, expressly required the use of an ultrashort-acting barbiturate, the *Pavatt* court found that the change was not sufficiently substantial to rise to the level of a legitimate claim of entitlement protected by due process. The *Pavatt* court also noted that Oklahoma's statute was "not entirely clear" whether the legislature used the term "ultrashort-

acting" in the sense of how quickly the drug took effect or the duration of effect. *Pavatt,* 627 F.3d at 1340, n. 3.

d. In *Jackson v. Danberg,* 656 F.3d 157, 160 (3rd Cir. 2011), the court observed that "[p]entobarbital is a barbiturate commonly used to euthanize terminally ill patients who seek death with dignity in states such as Oregon and Washington." Quoting *Beaty,* 649 F.3d at 1075 (denying rehearing *en banc* because inmate had no likelihood of success on 8th Amendment claim based on switch to pentobarbital).

e. In *Ferguson v. Florida State Prison,* 493 Fed.Appx. 22, *2 (11th Cir. 2012), the court stated that "the use of sodium pentobarbital as the first drug in the three-drug sequence does not constitute a substantial change" to Florida's execution protocol. *Valle v. Singer,* 655 F.3d 1223, 1230 (11th Cir. 2011)(replacement of sodium thiopental with pentobarbital does not constitute a significant alteration of the execution protocol).

f. *Powell v. Thomas,* 643 F.3d 1300, 1304 (11th Cir. 2011), noted the minimal differences between sodium thiopental and sodium pentobarbital, both being "classified as barbituates" and differing only "in their length of effect," which "simply means [that pentobarbital's] effect lasts longer than that of sodium thiopental."

g. In *Jordan v. Fisher,* 823 F.3d 805, 811 (5th Cir. 2016), where the state planned to use pentobarbital in the execution of three inmates, the inmates, like Rhines, complained that state law "prevent[ed] the state

from executing them using any drugs other than 'an ultrashort-acting barbiturate.'" The court ruled that switching from sodium thiopental to pentobarbital did not implicate any liberty interest.

The cases finding no significant difference between sodium thiopental and pentobarbital are consistent with the testimony of the experts who testified in Rhines' method of execution challenge (including Rhines' own expert, Dr. Heath) and the state's experiences with sodium thiopental and pentobarbital in prior executions.

Dr. Alan Dershwitz, an anesthesiologist, testified on behalf of the state. According to Dr. Dershwitz:

a. "[O]nce 5,000 mg [5g] of pentobarbital have been administered intravenously to an inmate, there is, to a reasonable degree of medical certainty, an exceedingly remote chance that the inmate could experience the effects of the subsequently administered pancuronium bromide . . . . A dose of 5,000 mg of pentobarbital will cause virtually all persons to stop breathing. In addition, a dose of 5,000 mg of pentobarbital will cause the blood pressure to decrease to such a degree that perfusion of blood to organs will cease or decline such that it is inadequate to sustain life . . . . [V]irtually every person given 5,000 mg of pentobarbital will have stopped breathing prior to the administration of pancuronium bromide. Thus, even in the absence of the administration of pancuronium bromide . . . the administration

of 5,000 mg of pentobarbital by itself would cause death in almost everyone." DERSHWITZ AFFIDAVIT at ¶¶ 12-13, Exhibit 7.

b. In finding no significant difference between sodium thiopental and pentobarbital, the *Pavatt* court stated Dr. Dershwitz's similar testimony in that case "persuasively characterized a 5,000 milligram dose of pentobarbital as 'an enormous overdose' that 'would cause a flat line of the EEG, which is the deepest measurable effect of a central nervous system depressant' and 'would be lethal as a result of two physiological responses:' the cessation of respiration and the drop in blood pressure 'to an unsurvivable level.'" *Pavatt,* 627 F.3d at 1339. The *Pavatt* court also stated that Dr. Dershwitz "credibly testified . . . that the 5,000 milligram dosage will give rise . . . to a virtually nil likelihood that the inmate will feel the effects of the subsequently administered vecuronium bromide." *Pavatt,* 627 F.3d at 1339. See also *Valle,* 655 F.3d at 1230 (finding Dr. Dershwitz's testimony that a massive dose of pentobarbital will reliably and swiftly produce death convincing).

c. In his videotaped testimony in Rhines' method of execution challenge, Dr. Dershwitz stated that:

   i. "When pentobarbital is injected intravenously, it has an onset of effect that is almost immediate. Within thirty to forty-five seconds after the drug reaches the brain, the person would be expected to

lose consciousness. DERSHWITZ TESTIMONY at 9/20, excerpt attached as Exhibit 3.

ii. "[P]entobarbital will have this profound effect to decrease circulation, it will stop breathing within a minute or two of its administration." DERSHWITZ TESTIMONY at 11/5, excerpt attached as Exhibit 3.

iii. When asked whether a 2-drug protocol of pentobarbital and a paralytic would have the same effect as he described above, Dr. Dershwitz testified that it would. DERSHWITZ TESTIMONY at 21/22, excerpt attached as Exhibit 3.

iv. When asked whether the descriptions provided by the warden of how Eric Robert and Donald Moeller had responded to a 5 gram (5,000 mg) dose of pentobarbital were consistent with the effects that he had previously described, Dr. Dershwitz testified "[y]es, and in fact, the warden's description, although given by a medical layperson, does not differ from what [he] observe[s] when [he] give[s] patients an intravenous drug to cause them to enter a general anesthetic state." DERSHWITZ TESTIMONY at 21/22, excerpt attached as Exhibit 3.

Dr. Mark Heath, an anesthesiologist, testified for Rhines in his method of execution challenge (and for the inmate in *Smith v. Mont. Dept. of Corrections,* 2015 WL 5827252 (Mont.Dist.1)). Dr Heath's prior testimony supports the state's position that pentobarbital meets the

same classification standards as sodium thiopental (which likely explains his conspicuous absence here at the end stage of Rhines' litigation):

a. Dr. Heath testified that, while "barbiturates are *typically* divided into classes, depending on how rapidly they exert their action and for how long the exert their action . . . there are different ways that people do it." According to Dr. Heath, "pentobarbital is *typically* put into the short- or medium-acting categories depending on which author is referring to it." Dr. Heath's testimony in Rhines' case (like his testimony in the *Smith* case) reflects that there are "different ways" to classify the same barbiturate depending on performance factors and application. HEATH RHINES TESTIMONY at 21/10, excerpt attached as Exhibit 8.

b. Dr. Heath, Rhines' own erstwhile expert, fudges noticeable with the adverb *typically*. "Typically" is hardly categorical, inherently admitting of contexts where it can meet the ultrashort-acting classification depending on recognized medical variables. One such context is in procedural sedation and analgesia in pediatric emergency medicine where physicians regard "[p]entobarbital [a]s an ultra-short acting barbiturate" that is "very useful for sedation prior to diagnostic imaging procedures" when "given intravenously." Meredith, *Pediatric Procedural Sedation And Analgesia,* 1:2 JOURNAL OF EMERGENCIES, TRAUMA AND SHOCK 88 (2008). In a high-dosage context, "pentobarbital – like the 'ultrashort-acting' drugs thiopental

and methohexital – is both a myocardial depressant (a decrease in SVI with unchanging PCWP) and a vasodilator (a decrease in SVRI and evidence for venodilation)." Todd, Drummond and Sang, *Hemodynamic Effects of High Dose Pentobarbital: Studies in Elective Neurosurgical Patients,* 20 NEUROSURGERY 559 (1987).

c. According to Dr. Heath, "[i]f the intended dose of pentobarbital were to be successfully delivered into the circulation of a person and carried to their brain in this dose [5,000 mg] it would cause complete depression of all the brain activity such that there would be no electrical activity in the brain whatsoever. The electrical activity of the brain sustains many important bodily functions, but in particular it sustain[s] respiration, the rhythmic breathing, that we do all the time and when pentobarbital *or any barbiturate* would stop all activity in the brain . . . [i]t would stop breathing from occurring." HEATH RHINES TESTIMONY at 23/3, excerpt attached as Exhibit 8.

d. In testimony given by Dr. Heath in the *Saar* case (which was used to impeach his testimony in Rhines' method of execution challenge) Dr. Heath testified that sodium thiopental, like pentobarbital, will produce death in 60 seconds. HEATH SAAR TESTIMONY at 70/16, 71/13, excerpt attached as Exhibit 9.

e. In Rhines' method of execution challenge, Dr. Heath testified that, like sodium thiopental, the respiratory arrest secondary to brain inactivity secondary to pentobarbital administration occurs within "60

seconds." HEATH RHINES TESTIMONY at 81/19, 87/4, excerpt attached as Exhibit 8.

f. In the *Cooey* case, when asked how long an execution would take using massive doses of sodium thiopental, Dr. Heath (in the context of a discussion concerning the efficacy of pentobarbital) stated that it "would be the same as using massive doses of some other anesthetic." HEATH COOEY TESTIMONY at 40, excerpt attached as Exhibit 10. In fact, believing that Ohio could not carry out an execution because it did not have *pentobarbital*, Dr. Heath extolled pentobarbital as superior to sodium thiopental and testified that it should be used *instead*. As an example, Dr. Heath referenced an execution using sodium thiopental that had taken 14 minutes start to finish and opined that "if you give a massive dose of pentobarbital, which can be done very quickly, in all likelihood the person is going to be dead in less time than that [*e.g.* less than 14 minutes]." HEATH COOEY TESTIMONY at 41, excerpt attached as Exhibit 10. When asked to describe the difference between administering pentobarbital and sodium thiopental, Dr. Heath testified that "[sodium] thiopental is given in large volumes, and so it takes a long time. It can take longer to get it in. One can give a comparable or a larger dose of pentobarbital more quickly." HEATH COOEY TESTIMONY at 41, excerpt attached as Exhibit 10. Dr. Heath even went so far as to state that, if states would simply use pentobarbital instead of sodium

thiopental "there would be no litigation, or at least I would not participate in the litigation, or I would work for your [the state's] side to say that I think this is a safe and humane procedure." HEATH COOEY TESTIMONY at 70, excerpt attached as Exhibit 10.

g. Dr. Heath, of course, did not testify for Montana when it switched to pentobarbital. Instead, in *Smith* (again on behalf of the inmate) Dr. Heath testified to the exact opposite of his testimony in *Cooey,* claiming that pentobarbital is *not* the "same as" sodium thiopental and is slower. Apparently not aware of Dr. Heath's *Saar* and *Cooey* testimony, the *Smith* court credited his testimony over the state's expert, Dr. Evans, because it believed Dr. Heath's *Smith* testimony was "consistent" with his testimony in certain, undescribed prior cases while Dr. Evans' allegedly was not. *Smith,* 2015 WL 58827252 at *4. The *Smith* court's lack of awareness of Dr. Heath's testimonial prevarication over the years undoubtedly influenced the court to believe that barbiturate classifications are stricter than they really are, and probably changed the outcome of the case. One wonders if the *Smith* court would have been so enamored of Dr. Heath if it had been aware of the sweeping inconsistencies in his testimony over the years and the widespread rejection of his opinions and testimony as a basis for holding a lethal injection protocol unconstitutional or for staying an execution by courts.[1]

h. While Rhines' current expert, Dr. Craig Stevens, lacks Dr. Heath's breadth of experience, he does not appear to lack the zeal for

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[1] *Durr v. Strickland,* 602 F.3d 789 (6th Cir. 2010)(Heath testimony alleging inmate suffered from allergy to anesthetic not sufficiently convincing to warrant stay); *Cooey v. Strickland,* 589 F.3d 210 (6th Cir. 2009)(Heath testimony focusing on risks of improper implementation of Ohio protocol did not raise constitutionally significant concerns warranting stay); *Grayson v. Allen,* 491 F.3d 1318 (11th Cir. 2007)(Heath testimony failed to present sufficient issue to prevent dismissal of inmate's claim); *Taylor v. Crawford,* 487 F.3d 1072 (8th Cir. 2007)(Heath testimony failed to convince court to hold method of execution protocol unconstitutional); *Workman v. Bredesen,* 486 F.3d 896 (6th Cir. 2007)(Heath affidavit did not establish likelihood of inmate's success on merits); *Brown v. Beck,* 445 F.3d 752 (4th Cir. 2006)(Heath testimony not persuasive enough to enjoin inmate's execution); *Cooper v. Rimmer,* 358 F.3d 655 (9th Cir. 2004)(Heath testimony failed to show that lethal injection procedure involved unnecessary risk of unconstitutional pain or suffering); *Brown v. Crawford,* 408 F.3d 1027 (8th Cir. 2005)(Heath affidavit failed to convince court to stay execution); *Cooey v. Strickland,* 2010 WL 1610608 (S.D.Ohio)(Heath failed to convince trial court that inmate's alleged anesthetic allergy likely to cause pain); *Cooey et al. v. Strickland,* 2009 WL 4842393 (S.D.Ohio) and *Cooey v. Strickland,* 610 F.Supp.2d 853 (Heath testimony failed to establish that inmate would likely succeed on claim challenging Ohio's lethal injection protocol); *Grayson v. Allen,* 499 F.Supp.2d 1228 (M.D.Ala. 2007)(Heath testimony failed to demonstrate inmate was entitled to a stay); *Hankins v. Quarterman,* 2007 WL 959040 (N.D.Tex.)(Heath testimony "fell short of showing that the inmate was subject to a risk of unconstitutional pain"); *Morales v. Hickman,* 415 F.Supp.2d 1037 (N.D.Cal. 2006)(despite Heath testimony, court found protocol constitutional); *Evans v. Saar,* 412 F.Supp.2d 519 (D.Md. 2006)(Heath testimony failed to establish that state's protocol was cruel and unusual); *Beardslee v. Woodford,* 2005 WL 40073 (N.D.Cal.)(Heath testimony insufficient to demonstrate any reasonable possibility inmate would be conscious after injection with sodium thiopental); *Reid v. Johnson,* 333 F.Supp.2d 543 (E.D.Va. 2004)(Heath testimony failed to establish inmate was likely to suffer irreparable harm as a result of state's lethal injection protocol); *Harris v. Johnson,* 376 F.3d 414 (S.D.Tex. 2004); *Ringo v. Lombardi,* 2011 WL 2584476 (W.D.Mo.)(finding Heath's testimony concerning use of non-medical personnel and use of drugs without a prescription failed to demonstrate inmate would suffer an injury in fact); *Baker v. Saar,* 402 F.Supp.2d 606 (D.Md. 2005)(Heath testimony did not warrant stay of execution); *Nooner v. Norris,* 2008 WL 3211290 (E.D.Ark. 2008)(Heath failed to convince court to stay execution); *In re: Lewis Williams,* 359 F.3d 811 (6th Cir. 2004)(inmate not entitled to stay of execution based on Heath affidavit); *Malicoat v. State,* 137 P.3d 1234 (Ct.App.Ok. 2006); *Broom v. Jenkins,* 2019 WL 1299846 (D.Ct.N.D.Ohio)(rejecting Dr. Heath's claim that it was not possible to access an inmate's vein and that execution team was "incompetent"); *Asay v. Florida,* 224 So.3d 695 (Fla. 2017)(rejecting Dr. Heath's testimony that use of etomidate in an execution posed a substantial risk of harm); *Ringo v. Roper,* 766 F.3d 880 (8th Cir. 2014)(denying stay of execution despite Dr. Heath's testimony against use of midazolam); *Muhammad v. Florida,* 132 So.3d 176 (Fla. 2013) and *Muhammad v. Florida,* 739 F.3d 683 (11th Cir. 2014); *Pardo v. Florida,* 108 So.3d 558 (Fla. 2012) and *Pardo v. Palmer,* 2012 WL 6106331 (D.Ct.Fla.)(denying stay of execution over Dr. Heath's assertion that pentobarbital would not sufficiently anesthetize inmate); *Thorson v. Epps,* 2011 WL 13177527 (D.Ct.N.D.Miss.)(affirming use of pentobarbital in lieu of sodium thiopental contrary to Dr. Heath's testimony that pentobarbital would not adequately anesthetize inmate).

distorting science in service of thwarting the implementation of the death penalty. In one of the 5 death penalty cases he appears to have participated in to date, the court ruled that Dr. Stevens' testimony was a "sham" because of the same methodological error underlying his testimony in this case – his classification structure and data are based on "clinical doses." *Loden v. State,* 264 So.3d 707, 712 (Miss. 2018). In *Loden,* Dr. Stevens testified to the alleged "ceiling effect" of midazolam. The *Loden* court criticized Dr. Stevens' methodology for extrapolating this "ceiling effect" "from studies conducted on cells in laboratory dishes (*in vitro*) and studies examining the blood concentration of midazolam in humans *who were administered clinical doses* of midazolam at five to fifteen milligrams." *Loden,* 264 So.3d at 712 (emphasis added). Dr. Stevens' persistence in testifying to midazolam's alleged "ceiling effect" according to clinical dosages is remarkable given that the *Loden* court found him guilty of the exact same "sham" midazolam methodology that *Glossip* had explicitly and soundly rejected three years earlier. Another court simply dismissed his testimony because he had failed to "cite probative support for his conclusions" about midazolam. *Jordan v. State,* 266 So.3d 986 (Miss. 2018).

i. Dr. Heath's tactic in *Smith* (and basically all cases in which he testifies), is to assert that a state should be using the drug it *doesn't* have. When Ohio had sodium thiopental, Dr. Heath claimed in *Cooey*

that pentobarbital was superior; when Montana had pentobarbital, Dr. Heath claimed sodium thiopental was superior. Dr. Heath is an avowed anti-death penalty zealot whose testimonial track record reveals more devotion to that cause than to objective medical science. HEATH RHINES TESTIMONY at 63/5-67/10, excerpt attached as Exhibit 8; HEATH SMITH DEPOSITION at 13/12, excerpt attached as Exhibit 11 (Dr. Heath wrote of his "strong opposition to the imposition of the death penalty").

Eyewitness accounts of executions conducted in South Dakota confirm that, as Dr. Heath himself has reported, pentobarbital is the "same as" sodium thiopental:

a. During the execution of Elijah Page (who tortured Chester Poage for hours – beating and kicking him, poisoning him, stabbing him, drowning him and ultimately beating his skull in with a rock), Warden Weber and other witnesses reported that the execution was performed "like clockwork" and that "it was just a matter of seconds" after the administration of sodium thiopental that Page started "snoring, and his chest heaved a couple times." WEBER 23AUG10 AFFIDAVIT at ¶ 7, Exhibit 12. Page's "death occurred within a matter of minutes." WEBER 23AUG10 AFFIDAVIT at ¶ 10, Exhibit 12.

b. As with Page, Eric Robert (who bludgeoned Correctional Officer Ron Johnson with a lead pipe, breaking his bones, amputating a finger, cracking his skull open and exposing his brain before suffocating him

with plastic wrap) was "conscious for only 45 seconds" following the administration of a massive dose of pentobarbital. Robert "expelled his last breath approximately 90 seconds" after administration of the drug. "Robert exhibited virtually no signs of pain or physical distress during either the seconds he remained conscious after the injection commenced or during the period of unconsciousness before he died. WEBER 22OCT12 AFFIDAVIT at ¶¶ 3, 4, Exhibit 13.

c. During the execution of Donald Moeller (who kidnapped, beat, stabbed, raped and cut the throat of 9-year-old Becky O'Connell), Moeller uttered a final sentence about 30 seconds after the warden signaled to commence the administration of the drugs. Moeller lost consciousness about 15 seconds later and "expelled a few last deep breaths approximately 60 seconds after [the warden] signaled to commence the injection." WEBER 1NOV12 AFFIDAVIT at ¶ 4, Exhibit 14. Media witnesses described the process as "very quick" and that Moeller was "gone" in "a matter of [a] minute." WEBER 1NOV12 AFFIDAVIT at ¶ 5, Exhibit 14.

The performance of pentobarbital during the executions of Robert and Moeller conform to Dr Heath's description in *Saar* of the performance of sodium thiopental in an execution setting – that sodium thiopental will produce death in 60 seconds. HEATH SAAR TESTIMONY at 70/16, 71/13, excerpt attached as Exhibit 9.

Which brings us to the debacle of facile statutory construction and result-oriented reasoning that is the *Smith* decision. As here, the inmate in *Smith* claimed that the use of pentobarbital for his execution did not conform to a statute requiring an "ultrashort-acting barbiturate." Applying a literal interpretation of the statute and rigid approach to general barbiturate classifications, the *Smith* court agreed and shamefully enjoined the use of pentobarbital for the execution of a vicious killer.[2]

a. The *Smith* court's decision rests on the central fallacy that the classification or performance of an ultrashort-acting barbiturate that the legislature had in mind was according to its use "in a clinical setting." Courts have consistently rejected the proposition that an execution is a medical procedure subject to medical or clinical standards.[3] In *Baze v. Rees,* 553 U.S. 35, 60 (2008), rejected the application of medical standards of practice to the execution context. Because medical standards are "drawn from a different context," they are not applicable in an execution setting. *Baze,* 553 U.S. at 60. See also *Walker v. Johnson,* 448 F.Supp.2d 719, 723 (E.D.Va. 2006)

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[2] *State v. Smith,* 705 P.2d 1087 (Mont. 1985)(Smith shot two men in the head point blank with a sawed-off .22 rifle in order to steal their car and "eliminate any witnesses" to his theft).

[3] See also *Gregg v. Georgia,* 428 U.S. 153, 173, 96 S.Ct. 2909 (1976)(constitution does not require the use of medically optimal standards in executions); *Ex parte Aguilar,* 2006 WL 1412666 (Tex.Crim.App. 2006)(doctors do not ordinarily prepare fluids for injection or insert or monitor IV lines in hospital settings); *Hamilton v. Jones,* 472 F.3d 814, 817 (10th Cir. 2007)(anesthetic monitoring as done in a surgical suite is not necessary in execution setting given the massive dosages of anesthetic administered).

("execution by lethal injection is not a medical procedure and does not require the same standard of care as one"). Even before *Baze, Emmett v. Johnson,* 511 F.Supp.2d 634, 642 (E.D.Va. 2007), ruled that making an "analogy to clinical medical standards in evaluating the methods used for conducting executions is without constitutional basis" because "surgery and execution have the polar opposite medical objectives." *Emmett,* 511 F.Supp.2d at 642.

b. For statutes, like SDCL 23A-27A-32, that are written to meet constitutional standards, the analogy to clinical medical standards is equally inapposite. Lethal injection is "designed to ensure a quick, indeed a painless death, and thus there is no need for" standards applicable to "a hospital surgery suite" where the goal "is to ensure that the patient will wake up at the end of the procedure." *Taylor v. Crawford,* 487 F.3d 1072, 1084 (8th Cir. 2007).

c. Despite the acknowledged discrepancy between clinical and execution standards, the *Smith* opinion repeatedly referenced clinical sources – testimony from Dr. Heath founded on the performance of "both pentobarbital and thiopental" "in a clinical setting," "significant research that classifies thiopental as being ultrashort-acting" when used *in a clinical setting,* some 28,600 search engine results describing sodium thiopental as ultrashort-acting *in a clinical setting,* a package insert classifying pentobarbital that had been manufactured for use *in a clinical setting* as short-acting. *Smith,* 2015

WL 5827252 at *3. *Smith* found clinical-based data such as these to be "[o]f significant import" to its decision. *Smith,* 2015 WL 5827252 at *3.

d. *Smith's* premise is flawed at its core. The *Smith* court apparently was oblivious to the then-recent decision of the United States Supreme Court in *Glossip v. Gross,* 135 S.Ct. 2726 (2015), in which the court expressly rejected measuring execution drug performance according to clinical standards. In *Glossip,* the inmate's expert, applying a clinical standard, opined that midazolam would not serve as a suitable anesthetic. To this Justice Alito replied:

> Petitioners emphasize that midazolam is not recommended or approved for use as the sole anesthetic during painful surgery, but there are two reasons why this is not dispositive. First, as the District Court found, the 500-milligram dose at issue here "is many times higher than a normal therapeutic does of midazolam." The effect of a small dose of midazolam has minimal probative value about the effect of a 500-milligram dose. Second, the fact that a low dose of midazolam is not the *best* drug for maintaining unconsciousness during surgery says little about whether a 500-milligram dose of midazolam is *constitutionally adequate* for purposes of conducting an execution. We recognized this point in *Baze,* where we concluded that although the medical standard of care might require the use of a blood pressure cuff and an electrocardiogram during surgeries, this does not mean those procedures are required for an execution to pass Eighth Amendment scrutiny.

Glossip, 135 S.Ct. at 2742, excerpt attached as Exhibit 15. Unlike the *Glossip* court, *Smith* failed to appreciate that the Montana legislature was not prescribing a barbiturate for use in a clinical setting; it was prescribing a drug for use in an execution setting. Comparing one to

the other is comparing apples to oranges . . . cheese to chalk . . . donuts to dumptrucks. *Glossip,* 135 S.Ct. at 2742, Exhibit 15.

e. As *Smith* correctly points out, and which is not disputed here, barbiturates are typically classified according to how quickly they wear off. Thus, "ultrashort-acting" and "short-acting" refer *not,* as the names might suggest to a layman, to the time it takes for the barbiturate to act on the system but to how long before it wears off. How *quickly* a barbiturate takes effect is described as "ultrafast-acting" or "fast-acting." *Smith* found that pentobarbital was short- and fast-acting based on its clinical classification and enjoined its use in Smith's execution. *Smith,* 2015 WL 5827252 at *5.

f. This was a glaring error. According to *Glossip,* the "probative" question is how a drug will perform in an execution. *Glossip,* 135 S.Ct. at 2742, Exhibit 15. According to *Glossip,* "[t]he relevant question" was whether midazolam was suitable in "the huge dose administered in the Oklahoma protocol." *Glossip,* 135 S.Ct. at 2743, Exhibit 15.

g. *Smith* did not address "[t]he relevant question;" instead it fixed on standards having "minimal probative value" to high-dosage administrations of pentobarbital. *Glossip,* 135 S.Ct. at 2743, Exhibit 15. Clearly the Montana legislature was not contemplating the clinical classification or properties of the barbiturate that it was prescribing for use in an execution. Prescribing a barbiturate for

execution based on a clinical propensity to wear off quickly (ultrashort-acting) would defeat the purpose of the execution. To administer a clinical dosage of sodium thiopental only to have Smith wake up 5-8 minutes later would thwart the purpose of execution and frustrate the statute. Thus, the Montana legislature clearly was not prescribing a barbiturate for execution purposes based on its ultrashort-acting properties in a clinical setting. The legislature clearly contemplated that any drug used would meet the performance criteria of an ultrafast-/ultrashort-acting drug in a high-dosage, execution setting.

h. In a clinical setting, an ultrafast-/ultrashort-acting barbiturate (according to Rhines' current expert, Dr. Stevens) will take effect "within 10-30" seconds." According to the testimony of Rhines' former expert, Dr. Heath, in *Saar,* an ultrafast-/ultrashort-acting barbiturate will take effect *and* shut down respiration in 60 seconds. According to Dr. Heath's deposition testimony in *Smith,* an ultrafast-/ultrashort-acting barbiturate takes effect in "20 to 30 seconds." HEATH SMITH DEPOSITION at 26/19, Exhibit 11. Elsewhere in his *Smith* testimony, Dr. Heath states that sodium thiopental administered at its "fastest possible" rate would still take "some tens of seconds to transition from full consciousness to full and deep unconsciousness." HEATH SMITH DEPOSITION at 79/15, Exhibit 11. This is the same as pentobarbital in an execution setting, which, according to Dr. Heath takes effect in

"several tens" of seconds, "10, 20, 30" seconds depending on variables like heart rate or how good an inmate's circulatory system is. HEATH SMITH DEPOSITION at 39/11, Exhibit 11.

i. Even if a clinical dose of pentobarbital would not act as fast as a clinical dose of sodium thiopental, Dr. Heath admitted in *Smith* that "[i]f one gave a dose [of pentobarbital] higher than, as with most drugs, the more one gives, the more rapidly one sees the effects." HEATH SMITH DEPOSITION at 30/9, Exhibit 11. According to Dr. Heath, the time it takes to travel from the injection site to the brain is the same for a large or small dose of a drug, but "all drugs that are used to produce sedation and unconsciousness will exert their effects at a more rapid rate if you give more." HEATH SMITH DEPOSITION at 31/4, Exhibit 11. In other words, high-dosage pentobarbital acts as fast or faster than a clinical dose of sodium thiopental.

j. Ultimately, it is not necessary to extrapolate the matching performance of clinical sodium thiopental and high-dosage pentobarbital from comparisons between Dr. Heath's vacillating testimony in his myriad cases. Dr. Heath put a bow on it in his *Smith* deposition testimony; when finally pushed to stop splitting hairs over clinical classifications and speculative administration mishaps, Dr. Heath was forced to admit in *Smith* that "[i]f proper administration of the drug occurs, *whether it is thiopental or pentobarbital,* if proper administration occurs in the intended multi-gram [execution setting]

dose into the circulation and carried to the brain, then there's *no difference between the drugs,* because both will produce deep unconsciousness that will outlast the duration of the execution." HEATH SMITH DEPOSITION at 89/22-90/5, Exhibit 11.

k. Just as a clinical dose of sodium thiopental would not be effective to perform an execution, it is just as clear that, in the context of an execution, sodium thiopental is *not* an ultrashort-acting barbiturate because it never wears off. In an execution setting, a 3-5 gram dose of sodium thiopental will "outlast the duration of the execution." HEATH SMITH DEPOSITION at 89/22-90/5, Exhibit 11. *Smith's* literal application of clinical classifications to an execution statute renders the statute inoperable; a clinical dose of sodium thiopental would not be sufficient to produce death, and the duration of effect of a lethal dose places the drug well outside the classification of ultrashort-acting.

l. Like *Glossip,* the *Pavatt* court noted the inherent contradiction of applying a strict clinical classification in an execution setting. *Pavatt* found that it was "not entirely clear" that Oklahoma's statute used the term "ultrashort-acting" in the clinical sense of how short it lasts. *Pavatt,* 627 F.3d at 1340 n. 3. Given that short action is not desirable in an execution context, the *Pavatt* court sensibly believed that the statute used the term ultrashort-acting "in a different sense, to refer to how quickly the barbiturate takes effect." *Pavatt,* 627 F.3d at 1340

n. 3. The *Pavatt* court's observation makes sense given the 8th Amendment mandate to eliminate to the extent possible any conscious suffering secondary to cessation of respiration.

m. Likewise, in *Owens v. Hill,* 758 S.E.2d 794, 802 (Ga. 2014), the court rejected the clinical mainstay of sterilized drugs as having any application in an execution setting. "[S]terility is simply a meaningless issue in an execution where, as the record showed, unconsciousness will set in almost instantaneously from a massive overdose of anesthetic, death will follow shortly afterward before consciousness is regained, and the prisoner will never have an opportunity to suffer the negative medical effects from infection or allergic reactions from a possibly non-sterile drug. Particularly unpersuasive is Hill's expert's testimony that certain contaminants also could have the following effect: 'Their blood pressure would drop precipitously, and ultimately its possible that they could die.' Such a side effect obviously would be shockingly undesirable in the practice of medicine, but it is certainly not a worry in an execution . . . . [S]uch a side effect would be irrelevant in an execution inducing nearly instantaneous unconsciousness and the rapid onset of death before consciousness is regained." *Owens,* 758 S.E.2d at 802.

In the *Smith* court's defense, its decision could only be as good as the evidence before it. The decision does not reflect that a *Glossip* argument was squarely presented to the *Smith* court. *Smith's* focus on

clinical classifications in texts, testimony, literature, manufacturer package inserts and other sources, and the fact that *Glossip* is not even mentioned in the opinion, rather affirmatively demonstrates that it was not. But, as *Glossip* found, clinical performance has "minimal probative value;" "the relevant question" is the drug's performance in the dosage administered in an execution. *Glossip,* 135 S.Ct. at 2742. The evidence conclusively demonstrates that execution dosages of pentobarbital meet the classifications of an ultrashort-acting barbiturate.

Consistent with *Glossip,* Dr. Joseph Antognini, a distinguished anesthesiologist, describes for the court how a "short-acting" drug can behave like an "ultrashort-acting drug," and *vice-versa,* depending on variables such as dosage or method of administration:

a. In high dosages "the actions of pentobarbital . . . are consistent with the actions of an ultra-fast acting/ultra-short acting barbiturate that is administered in a large lethal dose." ANTOGNINI REPORT at ¶ 11, Exhibit 16.
b. Barbiturate "classification is not absolute, and depends in large part on the dose of the drug and the route it is administered (oral versus intravenous)." ANTOGNINI REPORT at ¶ 12, Exhibit 16.
c. A prevailing textbook at the time of SDCL 23A-27A-32's codification reported that the classifications of barbiturates are "often altered depending on the route of administration (oral versus intravenous)

[and] dose." ANTOGNINI REPORT at ¶ 13, Exhibit 16, citing Miller, ANESTHESIA (1st Ed. 1981).

d. Studies report that classifications of barbiturates are so inexact, "dose-dependent," and archaic that "[i]t is surprising that th[ese] classification[s] still persist in pharmacology textbooks." ANTOGNINI REPORT at ¶¶ 14, 15, Exhibit 16.

e. A textbook written by Rhines' own expert in this case, Dr. Craig Stevens, demonstrates the fluidity of barbiturate classification. Though Dr. Stevens's report states that there are only "two ultra-short-acting barbiturates: sodium thiopental and methohexital," his textbook identifies both sodium thiopental *and* pentobarbital as short-acting. ANTOGNINI REPORT at ¶ 16, Exhibit 16, citing Brenner and Stevens, PHARMACOLOGY at 209, Table 19-1 (2018)(excerpt attached to ANTOGNINI REPORT. Dr. Stevens' table classifies pentobarbital administered orally by pill for insomnia as a short-acting barbiturate. He classifies the onset of the pill-form of the drug as fast. He does not have a classification for pentobarbital administered intravenously. As Dr. Heath has testified, drugs act faster when administered in higher dosages and, when pentobarbital is administered intravenously in a high dosage, it is no different than sodium thiopental. Dr. Stevens classifies an intravenous administration of sodium thiopental as short-acting, not ultrashort-acting. He classifies the onset of intravenous sodium thiopental as "very fast," not ultrafast. The fact

that Dr. Stevens himself fails to use the allegedly fixed and "widely accepted" nomenclature of "ultrafast" (or "ultrashort" when referring to Zaleplon's duration of action) is further evidence that, as Dr. Heath stated, there "are different ways that people" classify drugs "depending on which author is referring to it."

f. It is worth noting that Dr. Stevens' chart classifies every intravenously-administered drug as "very fast." Under the circumstances, it is reasonable to infer that he would likewise classify intravenously-administered pentobarbital as "very fast" or, in Dr. Heath's words, "the same as" sodium thiopental. Dr. Stevens' classification of sodium thiopental as "short," rather than "ultrashort" acting belies his testimony that barbiturate classifications are rigid *and* that there is any difference between sodium thiopental and pentobarbital.

g. According to Dr. Stevens, duration of action, like duration of onset, is a function of lipid solubility. Dr. Stevens testified that drugs that are more lipid soluble wear off more quickly than drugs that are less lipid soluble. Thus, the fact that Dr. Stevens classifies both sodium thiopental and pentobarbital as "short" signifies that their lipid solubility is the same, at least in his opinion when he approved this chart for publication in the textbook he wrote. And the fact that Dr. Stevens classifies all intravenously-administered drugs as "very fast" acting, and the fact that intravenous pentobarbital would likewise be

classified as "very fast," is further evidence that the lipid solubility of intravenous pentobarbital and intravenous sodium thiopental are the same, particularly in high dosages as Dr. Heath has said.

h. Barbiturates can meet different classification criteria depending on dosage. ANTOGNINI REPORT at ¶ 17, Exhibit 16; HEATH SMITH DEPOSITION at 89/22-90/5, Exhibit 11; HEATH COOEY TESTIMONY at 40, excerpt attached as Exhibit 10.

i. In the execution context, classification of sodium thiopental as "ultra-short acting" is "meaningless" because the drug's duration of action at that dosage would far exceed the time criterion for that classification. ANTOGNINI REPORT at ¶ 18, Exhibit 16. High dosage, intravenous administration alters pentobarbital's properties to match those of sodium thiopental in an execution setting. ANTOGNINI REPORT at ¶ 13, Exhibit 16, citing Miller, ANESTHESIA (1st Ed. 1981).

j. As noted in *Smith* and by Dr. Heath, "the purpose of the development of ultra-fast-acting barbiturates" is "a very quick transition from consciousness to unconsciousness." ANTOGNINI REPORT at ¶ 18, Exhibit 16. "[P]entobarbital at the dose administered in the South Dakota protocol (5 grams) would induce rapid unconscious within 20-30 seconds," consistent with the classification criteria of an ultrashort-acting barbiturate. ANTOGNINI REPORT at ¶¶ 20, 21, Charts C and D, Exhibit 16.

k. "[A] drug that is typically considered 'short-acting' can be 'ultra-short acting," and . . . an 'ultra-short acting' drug can be 'short-acting' depending on the variable of dosage" and route of administration. ANTOGNINI REPORT at Charts C and D, Exhibit 16. "When a drug is given intravenously, there is typically a vary rapid rise in the concentration . . . . A typical clinical dose is the general baseline for classifying drugs as 'ultrashort-' or 'short-acting.' But, since duration of action is a function of dosage, the classification can change if the dosage changes." ANTOGNINI REPORT at Charts C and D, Exhibit 16.

Here, the *Smith* decision was more instructive of what *not* to do than *what* to do. "[I]t is . . . a well-established canon of statutory construction that 'a statute susceptible of more than one meaning must be read in the manner which effectuates rather than frustrates the major purpose of the legislative draftsmen.'" *In re Goerg*, 844 F.2d 1562, 1567 (11th Cir. 1988), quoting *Schultz v. Louisianan Trailer Sales, Inc.*, 428 F.2d 61, 65 (5th Cir. 1970). "'[I]n cases where a literal approach would functionally annul the law, the cardinal purpose of statutory construction – ascertain legislative intent – ought not be limited to simply reading a statute's bare language; we must also reflect upon the purpose of the enactment, the matter sought to be corrected and the goal to be attained.'" *State v. Cameron*, 1999 SD 70, ¶21, 596 N.W.2d 49, 54,

quoting *Desmet Ins. of South Dakota v. Gibson*, 1996 SD 102, ¶7, 552 N.W.2d 98, 100.

As used in SDCL 23A-27A-32 as codified at the time of Rhines' conviction, the term "ultrashort-acting barbiturate" is arguably susceptible of two meanings – clinical or lethal. The state would argue that its meaning, in the context of a lethal injection statute, is limited to its properties as a lethal agent, but *Smith* demonstrates that minds can differ. Since "ultrashort-acting barbiturate" is susceptible of two meanings, it must be given a construction here that does not thwart the statute's purpose or render it an absurdity.

a. Rhines' interpretation of the statute is absurd for two reasons. First, a clinical dosage of sodium thiopental would not effect death; he would wake up in 5-8 minutes. Second, a lethal dosage of sodium thiopental is *not* ultrashort-acting. As Dr. Heath points out, sodium thiopental in a lethal dose will "outlast the duration of the execution." HEATH SMITH DEPOSITION at 89/22-90/5, Exhibit 11. As Dr. Antognini points out, this duration would exceed the time-criterion for ultrashort-acting. ANTOGNINI REPORT at ¶¶ 18, 20, Chart D, Exhibit 16. Rhines' literal interpretation would annul the statute because no drug could qualify. *Cameron*, 1999 SD 70 at ¶21, 596 N.W.2d at 54.

b. The state's interpretation is both logical and consistent with SDCL 23A-27A-32's purpose. In the context of a lethal injection statute, it makes more sense, as *Glossip* points out, to classify drugs based on

their lethal rather than clinical properties. And, as *Pavatt* pointed out, the performance metric of interest to the legislature was not how short the drug lasted but how quickly it took effect. All evidence, Rhines' own especially, demonstrates that pentobarbital acts in an ultrafast manner in an execution setting.

c. The legislature's intent in drafting SDCL 23A-27A-32 was to meet constitutional standards for execution and therefore must be interpreted in light of the numerous cases which have held that there is no constitutional difference between sodium thiopental and pentobarbital. If there is no constitutional difference, there is no statutory difference.

Rhines cannot demonstrate a "significant possibility" of succeeding on the merits of his claim. *Hill,* 547 U.S. at 584.

a. The claim is barred by *res judicata* because Rhines could have litigated this claim in the method of execution litigation before Judge Trimble in 2011. As noted just days ago by the South Dakota Supreme Court, Rhines' complaint for declaratory judgment and injunctive relief before Judge Trimble "argued that the state's protocols violated due process" and that the issue of the process due Rhines under SDCL 23A-27A-32 as codified on the date of his conviction was "fully litigated during a court trial, which included expert medical testimony." *Rhines v. S.D. Dept. of Corrections,* 2019 SD 59, ¶ 3. The Supreme Court noted that the "circuit court reviewed

the parties' evidence" and "made detailed findings of fact." *Rhines,* 2019 SD 59 at ¶4. Rhines filed a motion to appeal Judge Trimble's ruling but the Supreme Court "denied his motion, concluding that he had not demonstrated probable cause that an appealable issue existed." *Rhines,* 2019 SD 59 at ¶4. Rhines had a full and fair opportunity to litigate the state's alleged non-compliance with the process allegedly due him in his then-pending complaint for declaratory and injunctive relief. Though Rhines certainly could have, he did not take advantage of that opportunity to litigate this aspect of the method of his execution. There has been a final judgment rendered on the process due Rhines under the statute. *Rhines,* 2019 SD 59 at ¶4. Consequently, Rhines' claims are firmly barred by principles of *res judicata. Lippold v Meade Co. Bd. of Comm.,* 2018 SD 7, ¶28, 906 N.W.2d 917, 925.

b. Nor can Rhines prevail on the substance of his claims. Rhines' gimmick of applying clinical standards to the execution setting has been rejected by the United States Supreme Court in *Baze* and *Glossip.* Rhines' clinical interpretation of SDCL 23A-27A-32 would render the statute a nullity. Given the 8th Amendment constraints that necessarily guide the legislature's actions in this context, the legislature's selection of an ultrashort-acting barbiturate obviously was driven by the speed with which the drug took effect, not by how quickly it wears off. *Pavatt,* 627 F.3d at 1340 n. 3.

c. As Dr. Antognini points out, drugs can cross back and forth between classification boundaries depending on the method of administration and dosage given. Sodium thiopental administered in a low dosage at a slow rate would take effect slowly and wear off over a longer period of time; as such it could be considered slow-acting in terms of onset and short- or intermediate-acting in terms of duration. Pentobarbital administered in a massive dosage takes effect as fast as sodium thiopental or any other drug in the ultrashort-acting classification. ANTOGNINI REPORT at ¶¶ 12, 16, 18, 20, Charts C and D, Exhibit 16.

d. According to Rhines' own expert in the case before Judge Trimble, "there's *no difference between the drugs.*" HEATH SMITH DEPOSITION at 89/22-90/5, Exhibit 11. Indeed, when Dr. Heath was on the warpath against sodium thiopental in the *Cooey* case, he stated that "[o]ne can give a comparable or a larger dose of pentobarbital more quickly" than sodium thiopental. HEATH COOEY TESTIMONY at 41, excerpt attached as Exhibit 10. Given the United States Supreme Court's preference for measuring an execution drug's performance according to high-dosage metrics, the South Dakota Supreme Court's approval of the protocol as codified on the date of Rhines' conviction 27 years ago, and the intrinsic absurdity of applying clinical standards to a non-therapeutic process, Rhines stands no realistic chance of succeeding on the merits of his claim.

iii. Delay

A prisoners' long delay in pursuing a claim creates a strong equitable presumption against the grant of a stay. *McGehee v. Hutchinson,* 854 F.3d 488, 491 (8th Cir. 2018). "Given the state's significant interest in enforcing its criminal judgments, there is a strong equitable presumption against the grant of a stay where a claim could have been brought at such a time as to allow consideration of the merits without requiring entry of a stay." *Nelson,* 541 U.S. at 650. "[A] plaintiff cannot wait until a stay must be granted to enable him to develop facts and take the case to trial – not when there is no satisfactory explanation for the delay." *Sepulvado v. Jindal,* 729 F.3d 413, 420 (5th Cir. 2013), quoting *Reese v. Livingston,* 453 F.3d 289, 291 (5th Cir. 2006). A prisoner is not entitled to a stay in order to conduct discovery to make out a claim. *Beaty v. Brewer,* 649 F.3d 1071, 1075 (9th Cir. 2011).

Courts have often refused to grant a dilatory stay request sought on the eve of an execution. For example, in *McGehee,* a group of prisoners elected to forego certain federal claims and chose instead to challenge the execution protocol exclusively in state court. Only after the state supreme court rejected their state-law claims, and the Governor scheduled their executions, did the prisoners present a claim in federal court. *McGehee,* 854 F.3d at 491. The *McGehee* court overturned the district court stay of the scheduled executions because the 8th Amendment claims made in the federal litigation could have been

litigated at the same time as the earlier state claims. Without specifically addressing whether the claims were technically barred by *res judicata*, *McGehee* ruled that the prisoners' use of "piecemeal litigation" and dilatory tactics was sufficient reason by itself to deny a stay. *McGehee*, 854 F.3d at 491, quoting *Hill*, 547 U.S. at 584-85.

In *Ledford* the court denied a stay despite the fact that the inmate's claims were not necessarily barred by the statute of limitations because he had not been timely in waiting until five days before his execution to raise his claim. *Ledford*, 856 F.3d at 1315; *Crowe v. Donald*, 528 F.3d 1290, 1292 (11th Cir. 2008); *Diaz v. McDonough*, 472 F.3d 849, 851 (11th Cir. 2006); *Hill v. McDonough*, 464 F.3d 1256, 1259-60 (11th Cir. 2006). Also, in *Jones v. Allen*, 485 F.3d 635 (11th Cir. 2007), an inmate facing imminent execution filed a last-minute challenge to Alabama's protocol, which had been adopted four years earlier. The *Allen* court concluded that the inmate's delay "leaves little doubt that the real purpose behind his claim is to seek a delay of his execution, not merely to effect an alteration of the manner in which it is carried out." *Jones*, 485 F.3d at 640.

Similarly, here, South Dakota identified pentobarbital as one of two ultrashort-acting barbituates that would be used in its two-drug protocol 8 years ago. Rhines could have challenged the inclusion of pentobarbital in the 2-drug protocol 8 years ago. Yet, only 11 days from

the week set for his execution, Rhines raises this challenge for the first time.

Rhines has failed to show any equitable basis for excusing his delay under these circumstances. *Ledford,* 856 F.3d at 1312. He has been sentenced to death for 26 years and, only now, with his execution imminent, has he decided to challenge this aspect of the procedure for lethal injection that the state has had in place for the last 8 years. *Jones,* 485 F.3d at 640.

Though the *Smith* case held a full trial on the inmate's statutory compliance claim, the significant difference between this case and *Smith* is that Smith did not wait until the last minute to bring his claim. A year ago, Rhines, through the same lawyers that represent him here, brought a claim challenging the enactment of the policy on the grounds that it had not been promulgated by the APA. He should have brought this claim a year ago as well. This sort of last-minute, stay-baiting litigation is extremely prejudicial to the state because it forces the state to assemble a hasty defense and inhibits the state from marshalling its full best evidence against the claim.

The injustice of further delay is a particularly intolerable here considering that, because of his violent criminal history, Rhines would have been sentenced to life in prison for the burglary and his first, non-fatal stab wound to Donnivan Schaeffer's stomach. Rhines' capital sentence is his punishment for pounding a hunting knife into the base of

Donnivan Schaeffer's skull and killing him. But so far, all he has served is life in prison, the same sentence he would be serving if he had walked out after stabbing Donnivan just once and let him live. In other words, he has not yet been punished for murdering Donnivan. It is time for him to be punished for this killing. Equity howls against delay in this case.

CONCLUSION

Because Rhines failed to meet his burden of persuasion with a clear showing that law and equity favored his request for a stay of execution, the trial court erred in granting the motion.

Dated this 1st day of November 2019.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. I certify that Appellee's Brief is within the limitation provided for in SDCL 15-26A-66(b) using Bookman Old Style typeface in 12-point type. Appellee's Brief contains 9,999 words.

2. I certify that the word processing software used to prepare this brief is Microsoft Word 2010.

Dated this 1st day of November 2019.

Paul S. Swedlund
Paul S. Swedlund
Assistant Attorney General

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing brief was served on Daniel R. Fritz and Timothy Rahn via e-mail at fritzd@ballardspahr.com and rahnt@ballardspahr.com and Caroline Heller at hellerc@gtlaw.com.

Dated this 1st day of November 2019.

Paul S. Swedlund
Paul S. Swedlund
Assistant Attorney General

STATE OF SOUTH DAKOTA
COUNTY OF PENNINGTON

CHARLES R. RHINES

Petitioner,

vs.

DOUGLAS WEBER, Warden, South Dakota State Penitentiary,

Respondent.

IN CIRCUIT COURT
SEVENTH JUDICIAL CIRCUIT

CIV. 02-924

NOTICE OF ADOPTION OF REVISED EXECUTION POLICY AND PROTOCOL

Respondent Douglas Weber, by and through his counsel Paul S. Swedlund, Assistant Attorney General for the State of South Dakota, hereby files notice, as earlier requested by this court, of the method of execution policy and protocol prepared and adopted by respondent for use in the executions by lethal injection of condemned inmates in the State of South Dakota, including Charles R. Rhines. Respondent adopted this policy and protocol on October 19 and 13, 2011 respectively. The policy and protocol are modeled on, and are substantially similar to, one approved by the United States Supreme Court in *Baze v. Rees*, 553 U.S. 35, 128 S.Ct. 1520 (2008).

Respectfully submitted,

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Pennington County, SD
FILED
IN CIRCUIT COURT
OCT 24 2011
Ranae Truman, Clerk of Courts
By _____ Deputy

EXHIBIT
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 21st day of October 2011 a true and correct copy of the foregoing notice of adoption of revised execution policy and protocol was served by United States mail, first class, postage prepaid, on Jana Miner, Assistant Federal Public Defender, 101 South Pierre Street, Pierre, SD 57501.

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ERM A.12(B) Capital Punishment Final Days Procedures

A. GENERAL

1. The punishment of death shall be inflicted within the walls of a building at the State Penitentiary. SDCL §23A-27A-32, 23A-27A-33. The South Dakota State Penitentiary (hereinafter SDSP) shall provide all proper equipment and appliances for the infliction of such punishment. SDCL §23A-27A-32, 23A-27A-33. The necessary setup includes a room, hereinafter referred to as the "Chemical Room," equipped with a one-way mirror that allows occupants to observe the Execution Chamber and the inmate after he is strapped to a gurney in the execution chamber.

2. Death shall be inflicted by administering intravenous injections of a substance or substances in a lethal quantity. The substance or substances and manner of execution shall be and remain consistent with state and federal constitutional requirements as identified herein.

3. The Warden or designee is responsible for having the chemicals for lethal injection and any other necessary items for use on the scheduled date of execution. Under the direction of the Warden or designee two complete sets of the substance or substances used to conduct an execution shall be kept in separate secure locations.

4. The Warden shall arrange for the attendance of South Dakota Department of Corrections (hereinafter SDDOC) staff, law enforcement officers and other persons he/she deems necessary and proper to perform the functions involved in conducting a scheduled execution. This shall include all those required by South Dakota statute to attend.

5. If at any time during the execution process the Governor stays, pardons, or commutes the sentence of the condemned person or if a court of competent jurisdiction issues a stay after an execution has commenced, the execution team shall stop the execution. Ambulance staff equipped with advanced life support capabilities, including a heart defibrillator and such supplies and equipment as would be needed to attempt to revive an individual who has been injected with one or more of the substances identified in Section D, shall be on standby at the SDSP.

B. QUALIFICATIONS OF EXECUTION TEAM MEMBERS

1. An execution carried out by intravenous injection shall be performed by person(s) trained to perform venipuncture and to administer intravenous injections. The person(s) shall be selected by the Warden and approved by the Secretary of Corrections. SDCL 23A-27A-32.

2. The person(s) selected by the Warden to mix the drugs and prepare the syringes shall demonstrate proficiency through relevant training and two years' experience in the preparation of syringes for intravenous administration and mixing and preparation of drugs for such administration.

3. The person(s) selected by the Warden to insert the intravenous needles into the veins of the prisoner and connect, monitor, and maintain intravenous lines shall be certified or licensed and have at least two (2) years' professional experience as one of the following: medical or osteopathic physician, physician assistant, registered nurse, certified medical assistant, licensed practical nurse, phlebotomist, paramedic, emergency medical technician, or military corpsman.

4. The person(s) selected by the Warden to administer the injections shall demonstrate proficiency through relevant training and two years' experience in the administration of drugs by intravenous injection.

C. PREPARATION OF CHEMICALS

1. The following identifies the contents of each syringe used in the course of the 3-Drug or 2-Drug executions.

SYRINGE LABELED/MARKED	CONTENTS
#1	Sodium Thiopental (1.5 grams in a 60 cc solution) or Pentobarbital (2.5 grams in a 50 cc solution)
#2	Sodium Thiopental (1.5 grams in a 60 cc solution provided Syringe #1 is also 1.5 grams of Sodium Thiopental in a 60 cc solution) or Pentobarbital (2.5 grams in a 50 cc solution provided Syringe #1 is also 2.5 grams of Pentobarbital in a 50 cc solution)
#3	Normal Saline (25 ml)
#4	Pancuronium Bromide (100 mg of 2 mg/ml concentration in a 50 cc solution)
#5	Normal Saline (25 ml)
#6	Potassium Chloride (120 mEq. in a 60 cc solution)
#7	Potassium Chloride (120 mEq. in a 60 cc solution)
Backup syringes (if needed):	
#8	Normal Saline (25 ml)
#9	Sodium Thiopental (1.5 grams in a 60 cc solution) or Pentobarbital (2.5 grams in a 50 cc solution)
#10	Sodium Thiopental (1.5 grams in a 60 cc solution provided Syringe #1 is also 1.5 grams of Sodium Thiopental in a 60 cc solution) or Pentobarbital (2.5 grams in a 50 cc solution provided Syringe #1 is also 2.5 grams of Pentobarbital in a 50 cc solution)
#11	Normal Saline (25 ml)
#12	Pancuronium Bromide (100 mg of 2 mg/ml concentration in a 50 cc solution)
#13	Normal Saline (25 ml)
#14	Potassium Chloride (120 mEq. in a 60 cc solution)
#15	Potassium Chloride (120 mEq. in a 60 cc solution)

2. The following identifies the contents of each syringe used in the course of the 1-Drug execution using Sodium Thiopental.

SYRINGE LABELED/MARKED	CONTENTS
#1	Sodium Thiopental (1.25 grams in a 50 cc solution)
#2	Sodium Thiopental (1.25 grams in a 50 cc solution)
#3	Sodium Thiopental (1.25 grams in a 50 cc solution)
#4	Sodium Thiopental (1.25 grams in a 50 cc solution)
#5	Normal Saline (25 ml)
Backup syringes (if needed):	
#6	Sodium Thiopental (1.25 grams in a 50 cc solution)
#7	Sodium Thiopental (1.25 grams in a 50 cc solution)
#8	Sodium Thiopental (1.25 grams in a 50 cc solution)
#9	Sodium Thiopental (1.25 grams in a 50 cc solution)

3. The following identifies the contents of each syringe used in the course of the 1-Drug execution using Pentobarbital.

SYRINGE LABELED/MARKED	CONTENTS
#1	Pentobarbital (2.5 grams in a 50 cc solution)
#2	Pentobarbital (2.5 grams in a 50 cc solution)
#3	Normal Saline (25 ml)
Backup syringes (if needed):	
#4	Pentobarbital (2.5 grams in a 50 cc solution)
#5	Pentobarbital (2.5 grams in a 50 cc solution)

4. Any person sentenced to death prior to July 1, 2007, may choose to be executed by the 3- or 1-Drug protocol set forth in this document, provided the SDDOC possesses the necessary substance or substances for the method chosen at the time scheduled for the inmate's execution, or in the manner provided by South Dakota law at the time of the person's conviction (2-Drug protocol set forth in this document). Any person sentenced to death prior to July 1, 2007, shall be executed using the 3- or 1-Drug protocol provided in this document using the substance or substances in the SDDOC's possession unless the inmate requests in writing to the Warden not less than seven (7) days prior to the scheduled execution date that the inmate wishes to be executed by the 2-Drug protocol set forth herein in accordance with South Dakota law as it existed prior to July 1, 2007.

5. For any inmate sentenced to death after July 1, 2007, the Warden shall elect the method of execution from one of the foregoing 3-, 2-, or 1-Drug methods for which the SDDOC possesses the necessary substance or substances at the time scheduled for the inmate's execution. The Warden will give consideration to, and make the effort to accommodate, the inmate's method of preference, provided the inmate selects 3-, 2-, or 1-Drug methods for which the SDDOC possesses the necessary substance or substances at the time scheduled for the inmate's execution.

D. PREPARATION FOR EXECUTION

1. The SDDOC staff selected to participate in the execution shall drill at least weekly for six to eight weeks prior to the scheduled date of execution. The warden shall schedule additional drills the week of the scheduled execution.

2. Not less than seven (7) days prior to the execution week announced in the Warrant of Death Sentence and Execution, a physician or other medical professional qualified to assess venous access shall examine the inmate. A written report shall be prepared describing the inmate's physical condition and any medical condition of the inmate that may lead to potential problems establishing an IV site. This report, along with a copy of the lethal injection protocol, shall be provided to the executioner(s) for review and consideration no later than one day before the scheduled date of execution.

3. All substances will be mixed or prepared as necessary no more than 8 hours prior to the execution and shall thereafter be maintained in accordance with manufacturers' instructions in temperatures not in excess of 22°C/71.6°F, or such temperature specifically called for by the manufacturer, until ready for use. All substances will be mixed or prepared in bright, un-dimmed light.

4. To provide notification of any last minute stay or appeal, arrangements shall be made to provide direct telephone access between the Warden, the chemical room, the Governor's office, the Chief Justice of the South Dakota Supreme Court or designee, and the Attorney General's office. The Governor, the Chief Justice, and Attorney General or their designees shall be provided with phone numbers to the Warden's office, the chemical room, and multiple backup phone numbers (such as personal cell phone numbers of the Warden and Deputy Warden). In addition, the Warden and Deputy Warden shall be equipped with SDSP issued radios.

5. On the date of the scheduled execution, the prisoner shall be escorted to the execution chamber and strapped to the gurney by the Tie Down Team.

6. On the date of execution, the chemical room shall be kept clear of all persons except for the Executioners, the Warden, and any SDDOC staff selected by the Warden to assist with the execution of the sentence of death.

7. The Tie Down Team Leader shall verify that all restraints are secure and so advise the Warden, at which time the Tie Down Team shall move to the hallway and stand by.

8. The IV team shall enter the chamber and establish two independent IV lines to the inmate's veins. The IV team will establish IV lines only in peripheral veins located in the inmate's arms, hands, legs, or feet, preferably one in each arm. In the event the IV team cannot establish peripheral vein lines, the IV team will establish central vein lines by percutaneous methods, but only if the IV team member establishing the central vein line can demonstrate current training, credentialing, and proficiency in establishing IV lines in central veins by percutaneous methods. The IV team will establish and secure the IV lines in such a way as to leave them visible for monitoring.

9. The gurney shall at all times be placed so that the inmate's head and face are visible to the Warden and to those in the chemical room. If the inmate desires, and if it will not interfere with the efficacy of the substance or substances being used for the execution, the inmate's head will be propped up by a firm, foam wedge-shaped cushion to better permit IV team members in the chemical room to see the inmate's face during the procedure.

10. Every effort will be extended to ensure that no unnecessary pain or suffering is inflicted on the inmate.

11. If the IV team cannot secure one (1) or more sites within one (1) hour, the Governor's Office shall be contacted by the Secretary and a request shall be made that the execution be scheduled for a later date during the week of the execution, as set forth in the Warrant of Death Sentence and Execution.

12. The IV team shall start a saline flow and a sufficient quantity of saline solution shall be injected to confirm that the IV lines have been properly inserted and are not obstructed. IV team members will continue to monitor IV functioning from within the chemical room.

E. INJECTION PROCEDURES---3 DRUG PROTOCOL

1. The Warden shall make a final check with those authorities cited in Section D(4) to ensure no last minute appeals or stays have been filed.

2. Upon completion of preparation for execution (D. above), the Warden or designee shall order that blinds in front of witness rooms be opened and that the microphone in front of the inmate's mouth be turned on. The Warden or designee shall ask the prisoner if he/she has any last words to say. Upon completion of the prisoner's last words, or in the discretion of the Warden, the Warden shall order that the execution proceed.

3. Upon the Warden's order to proceed, a designated team member will begin a rapid flow of lethal chemicals in the following order.

4. Syringe #1

5. Syringe #2

6. Syringe #3

7. If it appears to the Warden that the prisoner is not unconscious within three (3) minutes after administration of the sodium thiopental or pentobarbital, the Warden shall order the flow of chemicals ceased into the primary site. The backup IV shall be used with a new flow of sodium thiopental or pentobarbital.

8. The Warden and IV team shall assess and monitor the inmate's lack of consciousness by using all steps in a graded consciousness check – a sequence of increasingly strong stimulations to assess consciousness – starting with checking for movement, eyelash reflex, response to verbal commands and culminating in a physical stimulation that would be painful if the inmate were awake. If possible, a currently certified EMT or other medical professional qualified in assessing consciousness, whose identity may, at the Warden's discretion, remain confidential, will be in the execution chamber with the Warden to assist the Warden in determining that the inmate is unconscious following the injection of the sodium thiopental or pentobarbital and prior to the administration of the pancuronium bromide and potassium chloride.

9. The Warden and IV team shall continuously monitor the IV and infusion sites. If the inmate appears unconscious three (3) minutes after the initial or backup flow of sodium thiopental or pentobarbital is complete, the executioner(s) shall commence the rapid flow of the remaining chemicals as follows.

10. Syringe #4

11. Syringe #5

12. Syringe #6

13. Syringe #7

14. Ten (10) minutes after the third drug is administered, the person(s) responsible for pronouncing death shall examine the inmate in order to confirm death by checking the inmate's heartbeat, breathing, pulse and pupils. If the inmate's death is confirmed, the person(s) shall inform the Warden. If that person(s) is unable to confirm the inmate's death, the Warden shall order injection of the remaining backup syringes.

15. Once the person(s) responsible for pronouncing death has confirmed the inmate's death, the Warden shall announce "At approximately _____ a.m./p.m. the execution of [inmate's name] was carried out in accordance with the laws of the State of South Dakota" or a similar statement to that effect.

16. The microphone shall be turnned off and the curtains/blinds shall be drawn.

17. The witnesses shall be escorted out of the witness rooms and shall sign the Certificate of Execution as required by South Dakota law.

F. INJECTION PROCEDURES—2 DRUG PROTOCOL

1. The Warden shall make a final check with those authorities cited in Section D(4) to ensure no last minute appeals or stays have been filed.

2. Upon completion of preparation for execution (D. above), the Warden or designee shall order that blinds in front of witness rooms be opened and that the microphone in front of the inmate's mouth be turned on. The Warden or designee shall ask the prisoner if he/she has any last words to say. Upon completion of the prisoner's last words, or in the discretion of the Warden, the Warden shall order that the execution proceed.

3. Upon the Warden's order to proceed, a designated team member will begin a rapid flow of lethal chemicals in the following order.

4. Syringe #1

5. Syringe #2

6. Syringe #3

7. If it appears to the Warden that the prisoner is not unconscious within three (3) minutes after administration of the sodium thiopental or pentobarbital the Warden shall order the flow of chemicals ceased into the primary site. The backup IV shall be used with a new flow of sodium thiopental or pentobarbital.

8. The Warden and IV team shall assess and monitor the inmate's lack of consciousness by using all steps in a graded consciousness check – a sequence of increasingly strong stimulations to assess consciousness – starting with checking for movement, eyelash reflex, response to verbal commands and culminating in a physical stimulation that would be painful if the inmate were awake. If possible, a currently certified EMT or other medical professional qualified in assessing consciousness, whose identity may, at the Warden's discretion, remain confidential, will be in the execution chamber with the Warden to assist the Warden in determining that the inmate is unconscious following the injection of the sodium thiopental or pentobarbital and prior to the administration of the pancuronium bromide and potassium chloride.

9. The Warden and IV team shall continuously monitor the IV and infusion sites. If the inmate appears unconscious three (3) minutes after the initial or backup flow of sodium thiopental or pentobarbital is complete, the executioner(s) shall commence the rapid flow of the remaining chemicals as follows.

10. Syringe #4

11. Syringe #5

12. Ten (10) minutes after the second drug is administered, the person(s) responsible for pronouncing death shall examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils. If that person(s) is not able to pronounce death, the Warden shall order injection of the remaining backup syringes.

13. Once the person(s) responsible for pronouncing death has confirmed the inmate's death, the Warden shall announce "At approximately _____ a.m./p.m. the execution of [inmate's name] was carried out in accordance with the laws of the State of South Dakota" or a similar statement to that effect.

14. The microphone shall be turned off and the curtains/blinds shall be drawn.

15. The witnesses shall be escorted out of the witness rooms and shall sign the Certificate of Execution as required by South Dakota law.

G. INJECTION PROCEDURES – 1 DRUG PROTOCOL (Sodium Thiopental)

1. The Warden shall make a final check with those authorities cited in Section D(4) to ensure no last minute appeals or stays have been filed.

2. Upon completion of preparation for execution (D. above), the Warden or designee shall order that blinds in front of witness rooms be opened and that the microphone in front of the inmate's mouth be turned on. The Warden or designee shall ask the prisoner if he/she has any last words to say. Upon completion of the prisoner's last words, or in the discretion of the Warden, the Warden shall order that the execution proceed.

3. Upon the Warden's order to proceed, a designated team member will begin a rapid flow of lethal chemicals in the following order.

4. Syringe #1

5. Syringe #2

6. Syringe #3

7. Syringe #4

8. Syringe #5

9. Ten (10) minutes after the drug is administered, the person(s) responsible for pronouncing death shall examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils. If that person(s) is not able to pronounce death, the Warden shall order a second set of chemicals to be administered in the following order.

10. Syringe #6

11. Syringe #7

12. Syringe #8

13. Syringe #9

14. Ten (10) minutes after the second round of the drug is administered, the person(s) responsible for pronouncing death shall again examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils.

15. Once the person(s) responsible for pronouncing death has confirmed the inmate's death, the Warden shall announce "At approximately _____ a.m./p.m. the execution of [inmate's name] was carried out in accordance with the laws of the State of South Dakota" or a similar statement to that effect.

16. The microphone shall be turned off and the curtains/blinds shall be drawn.

The witnesses shall be escorted out of the witness rooms and shall sign the Certificate of Execution as required by South Dakota law.

H. INJECTION PROCEDURES – 1 DRUG PROTOCOL (Pentobarbital)

1. The Warden shall make a final check with those authorities cited in Section D(4) to ensure no last minute appeals or stays have been filed.

2. Upon completion of preparation for execution (D. above), the Warden or designee shall order that blinds in front of witness rooms be opened and that the microphone in front of the inmate's mouth be turned on. The Warden or designee shall ask the prisoner if he/she has any last words to say. Upon completion of the prisoner's last words, or in the discretion of the Warden, the Warden shall order that the execution proceed.

3. Upon the Warden's order to proceed, a designated team member will begin a rapid flow of lethal chemicals in the following order.

4. Syringe #1

5. Syringe #2

6. Syringe #3

7. Ten (10) minutes after the drug is administered, the person(s) responsible for pronouncing death shall examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils. If that person(s) is not able to pronounce death, the Warden shall order a second set of chemicals to be administered in the following order.

8. Syringe #4

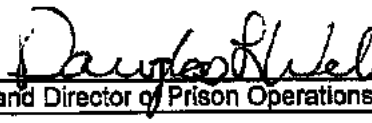
9. Syringe #5

10. Ten (10) minutes after the second round of the drug is administered, the person(s) responsible for pronouncing death shall again examine the inmate. The person(s) responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse and pupils.

11. Once the person(s) responsible for pronouncing death has confirmed the inmate's death, the Warden shall announce "At approximately _____ a.m./p.m. the execution of [inmate's name] was carried out in accordance with the laws of the State of South Dakota" or a similar statement to that effect.

12. The microphone shall be turned off and the curtains/blinds shall be drawn.

The witnesses shall be escorted out of the witness rooms and shall sign the Certificate of Execution as required by South Dakota law.

Douglas L. Weber 	October 13, 2011
Douglas L. Weber, Chief Warden and Director of Prison Operations	Date

1.3.D.3 Execution of an Inmate

I Policy Index:

Date Signed: *10/19/2011*
Distribution: *Public*
Replaces Policy: *N/A*
Supersedes Policy Dated: *09/22/2011*
Affected Units: *Adult Institutions*
Effective Date: *10/19/2011*
Scheduled Revision Date: *July 2012*
Revision Number: *7*
Office of Primary Responsibility: *DOC Administration*

II Policy:

The Department of Corrections (DOC) will carry out the execution of an inmate in accordance with SDCL Chapter § 23A-27A. The execution will be conducted in a professional, humane and dignified manner.

III Definitions:

Lethal Injection:
The intravenous injection (IV) of a substance or substances in a lethal quantity (See SDCL § 23A-27A-32).

Witnesses:
People authorized to attend an execution as referenced in SDCL §§ 23A-27A-34 and 23A-27A-34.2.

IV Procedures:

1. General Provisions:

A. Inmate executions are carried out by means of lethal injection. (See SDCL § 23A-27A-32)

1. At no time will any medical professional(s) employed at a South Dakota Department of Corrections facility participate in the execution process.
2. Lethal injection is not the practice of medicine in South Dakota (See SDCL § 23A-27A-32).
3. The inmate who is to be executed will be connected to two (2) IV lines, normally one (1) in each arm. One (1) IV line will be the primary line for the lethal injection and the other IV line is designated as a backup.
4. The lethal injection process involves the administration of drugs s, each in a lethal quantity, pursuant to a 3-Drug, 2-Drug, or 1-Drug protocol, depending on the date of the inmate's conviction and the availability of the necessary drugs:

   a. 3-Drug Protocol

i. The first drug, Sodium Pentothal (aka Sodium Thiopental) or Pentobarbital, is administered in a quantity sufficient to ensure the inmate is not subjected to the unnecessary and wanton infliction of pain.

ii. The second drug, Pancuronium Bromide, stops the inmate's breathing.

iii. The third drug, Potassium Chloride, stops the inmate's heart.

b. 2-Drug Protocol

i. The first drug, Sodium Pentothal (aka Sodium Thiopental) or Pentobarbital, is administered in a quantity sufficient to ensure the inmate is not subjected to the unnecessary and wanton infliction of pain.

ii. The second drug, Pancuronium Bromide, stops the inmate's breathing.

c. 1-Drug Protocol - Sodium Pentothal (aka Sodium Thiopental) or Pentobarbital is administered in a lethal quantity sufficient to ensure the inmate is executed without the unnecessary and wanton infliction of pain.

5. Any person convicted of a capital offense or sentenced to death prior to July 1, 2007 may choose to be executed in the manner provided in this policy or in the manner provided by South Dakota law at the time of the person's conviction or sentence (SDCL § 23A-27A-32.1).

a. The inmate will indicate their choice in writing to the Warden not less than seven (7) days prior to the scheduled week of execution.

b. If the inmate fails or refuses to choose in the time provided, then the inmate will be executed as provided by state law at the time of the execution (See SDCL § 23A-27A-32.1).

B. The execution is conducted under the direction of the SDSP Warden.

1. The Warden will select qualified staff to participate in the execution.

2. The Warden will identify one (1) or more individuals trained to administer intravenous injections to carry out the lethal injection.

a. The Warden will present information regarding the individual(s) qualifications to the Secretary of Corrections for final approval (See SDCL § 23A-27A-32).

b. The individual(s) qualifications must demonstrate adequate training to competently carry out each technical step of the lethal injection (See Baze v. Rees, 553 U.S. 35 (2008) and Taylor v. Crawford, 487 F. 3d 1072 (8th Cir. 2007).

c. The name, address, or other identifying information relating to the identity of any person or entity supplying drugs for use in intravenous injections under SDCL § 23A-27A is confidential and disclosure of such information may not be authorized except pursuant to the terms of a court order.

d. The name, address, qualifications and other identifying information relating to the identity of any person administering the intravenous injections under SDCL § 23A-27A is confidential and disclosure of such information may not be authorized or ordered. Disclosure of this information is a Class 2 Misdemeanor (See, SDCL § 23A-27A-31.2).

C. Male inmates sentenced to death will be housed in the SDSP or the Jameson Prison Annex. Female inmates sentenced to death will be housed at the South Dakota Women's Prison (See DOC policy 1.3.D.2 - *Capital Punishment Housing*).

1. Inmates sentenced to death are segregated from other inmates and single celled (See SDCL § 23A-27A-31.1).

2. Physical access to an inmate sentenced to death is limited to family, attorney(s), clergy, DOC staff, other state or contractual staff stationed at the respective prison, people authorized by the respective Warden or any other person authorized to access the inmate through a court order (See SDCL § 23A-27A-31.1).

D. The Governor may investigate the circumstances of the case of the inmate sentenced to death in a manner he deems appropriate and may require the assistance of the Attorney General (See SDCL § 23A-27A-19). The Governor has the power to reprieve or suspend the execution for up to ninety (90) days to complete his investigation (See SDCL § 23A-27A-20).

E. If there is a question on an inmate's mental competence to proceed with the execution, the Warden will notify the Governor, Secretary of Corrections and the sentencing court. If the sentencing court determines that there is a substantial threshold showing of incompetence to be executed, the sentencing court will conduct hearings and order mental examinations.(See SDCL § 23A-27A-22, through § 23A-27A-26). As long as an inmate is considered incompetent, that inmate may not be executed (See SDCL §§ 23A-27A-24 and 23A-27A-26).

F. The death penalty cannot be imposed on a person who was mentally retarded at the time of the commission of the offense and whose condition was manifested and documented before the age of eighteen (18) (See SDCL §§ 23A-27A-26.1 through 23A-27A-26.7).

G. A pregnant women may not be executed (See SDCL §§ 23A-27A-27 through 23A-27A-29).

H. The death penalty cannot be imposed on a person who committed an act punishable by death while under eighteen (18) years of age (See SDCL § 23A-27A-42).

I. Inmate appeals regarding the death penalty are outside the responsibility of the DOC. Inquiries on the status of any inmate appeal(s) should be directed to the Office of the Attorney General or the defense attorney(s).

2. Warrant of Execution:

A. The sentencing judge (or successor in office) will have a signed and certified Warrant of Death Sentence and Execution provided to the Warden of the state penitentiary (See SDCL §§ 23A-27A-15 and 23A-27A-16).

B. The Warrant of Death Sentence and Execution will set the week within which the inmate is to be executed (See SDCL § 23A-27A-15).

C. The Warden of the state penitentiary may carry out the execution at any time within the week stated in the Warrant of Death Sentence and Execution. (See, SDCL §§ 23A-27A-15 and 23A-27A-16).

3. Time and Place of Execution:

A. All executions will take place at the SDSP (See SDCL § 23A-27A-32).

B. The day and hour set by the Warden of the state penitentiary for the execution will be kept secret and only divulged to those invited or requested to be present at the execution (See SDCL § 23A-27A-37).

C. No person will divulge the day and hour set for the execution prior to the Warden's public announcement (See SDCL § 23A-27A-37).

D. The Warden of the state penitentiary will publicly announce the day and hour of the execution not less than forty-eight (48) hours in advance (See SDCL § 23A-27A-17).

4. Selection of Witnesses:

A. No person under the age of eighteen (18) will be allowed to witness an execution (See SDCL § 23A-27A-36).

B. Only persons authorized by the Warden of the state penitentiary, and witnesses authorized by SDCL §§ 23A-27A-32, 23A-27A-34, 23A-27A-34.1, 23A-27A-34.2 and 23A-27A-36 are allowed to attend the execution.

1. The following witnesses are required to be invited to witness the execution by state law (See SDCL § 23A-27A-34):

   a. The Attorney General of South Dakota.

   b. The trial judge before whom the conviction occurred or his/her successor in office.

   c. The State's Attorney of the county where the crime was committed.

   d. The Sheriff of the county where the crime was committed.

C. The Warden of the state penitentiary will select a number of reputable adult citizens to witness the execution and two (2) members of the media (See section on Media Relations).

1. Space and seating for witnesses is limited by the size of the rooms, the viewing windows and concerns for the safety and security of the witnesses.

2. Preference will be given to accommodating as many representatives of the victim as possible given the space constraints and the requirements in state law that other persons also serve as witnesses.

D. There are no specific statutory requirements for how the Warden of the state penitentiary selects which representatives of the victim(s) may witness the execution.

1. The victim's family or families may suggest the names of individuals who should attend.

2. In the event the victim's family or families cannot or will not prioritize their list of individuals, the Warden of the state penitentiary will make the choice in the following manner:

   a. Close relatives of victim(s) are given preference to witness the execution. A "close relative" is determined in the following order of preference:
      1). Spouse.
      2). Parent(s) or stepparent(s).
      3). Adult children, including stepchildren.
      4). Brother(s) or sister(s).
      5). Other family members (grandparents, aunts, uncles, nieces, nephews, cousins, etc.).

   b. Friends of the victim (if there are less than five close relatives of a victim attending).

E. The Warden of the state penitentiary has final approval of all witnesses not specifically required by law to be invited.

F. All witnesses other than the Attorney General, trial judge, States Attorney and Sheriff are subject to the same background check as a regular visitor, unless exempted by the Warden of the state penitentiary.

G. The inmate is allowed to request the attendance of up to five (5) persons to serve as witnesses. These persons may include but are not limited to legal counsel, members of the clergy, relatives or friends (See SDCL § 23A-27A-34.2). All the requested witnesses shall be on the inmate's visit list and at least eighteen (18) years of age (See DOC policy 1.5.D.1 *Inmate Visiting).*

5. Witness Behavior:

A. Because the execution will take place inside a facility where many other inmates and staff will be present or in close proximity, all witnesses are expected to follow the rules and procedures of SDSP and the orders of escorting staff for the safety and security of all involved.

1. Failure to comply with the rules and procedures of SDSP or the orders of escorting staff may result in denial of entry or removal of the witness from the facility.

2. Witnesses are expected to follow the dress code for visitation. The witnesses will be provided this specific information in advance of the execution (See DOC policy 1.5.D.1 *Inmate Visiting).*

3. Witnesses are subject to search by both a stationary and hand-held metal detector, and pat searches at any time (See DOC policy 1.3.A.5 *Searches - Adult Institutions*).

   a. Witnesses may be searched more than one (1) time prior to the execution.

   b. To the extent possible, pat searches will be conducted by a staff member of the same sex as the witness.

4. Most personal property items are not allowed inside the SDSP.

   a. For example, purses, cameras, pictures, pocketknives, pagers, watches, cell phones, signs, recording devices, other electronic equipment, etc. are not permitted. These items should be left in the vehicle or lockers that are available for storage of personal property in the SDSP lobby (See DOC policy 1.3.A.10 - *Restrictions on Electronic Equipment*).

   b. No drugs, alcohol, tobacco products or firearms are allowed inside SDSP. Anyone suspected of being under the influence of drugs or alcohol will be denied entry or removed from the facility.

B. All witnesses are cautioned to refrain from verbal outbursts or inappropriate action while inside the SDSP.

C. No cameras or recording devices of any type are allowed inside the SDSP, the witness area or the area surrounding the execution chamber.

6. Media Relations:

A. Requests for execution information (other than appeal issues) or interviews from media representatives are to be made either to the DOC Communications and Information Manager or to the respective Warden (See DOC policy 1.1.A.4 *Relationship with News Media, Public and Other Agencies*).

1. The Warden (or designee) can discuss procedures under the control of SDSP that affect an execution. Examples of procedures which may be discussed:
    a. The timelines of the execution, from issuance of the warrant of execution to the certificate of execution, return of the deceased inmate's body and the burial.
    b. The various steps that go along with the execution; i.e. sequence of events, last meal, last words, etc.
    c. Witness information (See sections on Selection of Witnesses and Witness Behavior).
    d. A description of the regular visit procedures inside the security perimeter.
2. Questions on the process of the Governor to investigate the circumstances of the case will be directed to the Governor's Office or to the Attorney General's Office.

B. The decision to grant tours of the execution chamber is at the total discretion of the Warden of the state penitentiary.

C. The decision to grant photo/video of the execution chamber is subject to the approval of the Secretary of DOC.

D. The two (2) media witnesses who will attend the execution will be selected as follows:
    1. The first media representative will be selected from the Associated Press.
    2. The second media representative will be selected from a media outlet located in the proximity of where the crime took place.

E. No cameras or recording devices of any type are allowed in the witness area or the surrounding area of the execution chamber.
    1. Each media witness attending the execution may have writing material in the waiting area but must leave those materials behind when moved to the witness area.
    2. Each media witness attending the execution will be given paper and a pencil once he/she arrives in the witness area.

7. Final Visit Arrangements:

A. Reasonable accommodations for visits by immediate family will be made after the inmate has been moved to a holding cell near the execution chamber.
    1. Visits are allowed between 8:00 AM and 8:00 PM, except for the day of the execution (See item "E" in this section).
    2. All personal visits will be Class II (non-contact) (See DOC policy 1.5.D.1 *Inmate Visiting).*
    3. Telephone calls may be substituted for personal visits.

B. Visits will be supervised by DOC staff and must be arranged in advance through the Warden or Deputy Warden.
    1. Visitors are subject to search by both a stationary and hand-held metal detector, and pat searches at any time (See DOC policy 1.3.A.5 *Searches - Adult Institutions*).
    2. Visitors must abide by the rules and regulations of the SDSP and the DOC.

3. Failure to abide by the rules and regulations of the SDSP and the DOC may result in termination of a current visit and denial of future visits.

C. Visitors will be escorted and supervised at all times.

D. The following members of the inmate's immediate family are allowed Class II visits with the inmate: father, mother, stepfather, stepmother, brother(s), sister(s), stepbrother(s), stepsister(s), biological children and spouse.

E. Visits with immediate family will cease at least six (6) hours prior to the scheduled time of execution.

F. Attorney access will be accommodated as much as possible.

1. Attorneys are subject to all the visit arrangements/restrictions listed in this section .

2. Any documents that need to be shared with the inmate will be passed to SDSP staff, inspected for contraband and if approved, the documents will be given to the inmate.

3. Attorney(s) must leave the holding cell area at least one (1) hour before the scheduled execution time.

G. Clergy will be allowed additional visits with the inmate until one (1) hour before the scheduled execution time.

8. The Execution:

A. An execution involves strict security procedures that are intended to protect the witnesses, staff, other inmates and the public at large. These security procedures are confidential and will not be discussed.

B. The Governor, Attorney General and Chief Justice of the State Supreme Court or their designees will be provided with the telephone numbers of the Warden's Office, the chemical room and multiple backup telephone numbers including personal cell phone numbers of the Warden and Deputy Warden for the purpose of emergency or last minute notification. The Warden and Deputy Warden will also be equipped with SDSP-issue radios.

C. After confirming with the Governor's Office, the Attorney General and the Chief Justice of the State Supreme Court that no last minute appeals have been initiated and that no stays have been ordered, the inmate will be moved to the execution chamber and secured to the table.

D. Two (2) intravenous injection (IV) sites will be prepared and inserted, normally one (1) in each of the inmate's arms.

E. A bag of sterile saline solution will be connected to each IV site. Each IV will be checked and verified as running properly before witnesses are escorted into the viewing rooms.

F. The witnesses will be brought into the respective witness rooms one (1) group at a time.

G. The curtains outside the witness rooms will remain closed until the Warden is satisfied, everything is ready and orders them opened.

H. The Warden will give the inmate an opportunity to make a final statement. A transcript will be made of the inmate's statement and the transcript will be made public.

I. For 3-Drug or 2-Drug protocol executions, the Sodium Pentothal or Pentobarbital will be administered and allowed to take effect prior to administering the subsequent drugs.

J. After the lethal injections have been administered, the Warden will wait a brief period before summoning a person capable of examining the inmate for the presence of respirations and heartbeat and if appropriate to pronounce death, including the time of death.

1. If the county coroner is on the premises, the Warden will ask the county coroner to certify death, including the time of death and then take charge of the body.

2. If the county coroner is not on the premises, the Warden will direct the inmate's body to be taken to a nearby morgue, where the county coroner will be summoned to examine it and certify death.

K. After death has been pronounced, the curtains of the witness rooms will be closed and the witness groups will be escorted away from the area separately.

9. Post-Execution Procedures:

A. The certificate of execution and return will be prepared and signed by the Warden and the certificate of execution will also be signed by all witnesses present and witnessing the execution (See SDCL §§ 23A-27A-34, 23A-27A-34.2 and 23A-27A-40.1).

B. The Warden will ensure the county coroner is permitted to investigate the death pursuant to SDCL §§ 23-14-18(3) and 24-1-27

1. If the county coroner is on the premises, the body of the executed inmate will not be removed from the execution chamber until after the county coroner has certified the death of the inmate.

C. After the county coroner has completed the investigation, the body of the executed inmate (unless claimed by some relative), will be interred in a cemetery within Minnehaha County (Also see SDCL § 23A-27A-39 and DOC policy 1.4.E.6 - *Management of Offender Deaths*).

D. After the execution has been completed, the DOC Communication and Information Manager will announce the fact in a press briefing that will be conducted elsewhere on the SDSP grounds.

E. Media representatives present at the execution are required to attend the post-execution press conference to share information about the execution with other media.

F. Within ten (10) days following the execution, the certificate of execution and return will be filed with the Clerk of Courts of the county where the offense occurred. (See SDCL § 23A-27A-40.1)

V Related Directives:

SDCL chapter 23-14, chapter 23A-27A and 24-1-27
Baze v. Rees, 553 U.S. 35 (2008)
Taylor v. Crawford, 487 F. 3d 1072 (8th Cir. 2007)
DOC policy 1.1.A.4 *Relationship with News Media, Public and Other Agencies*
DOC policy 1.3.A.5 -- *Searches - Adult Institutions*
DOC policy 1.3.A.10 – *Restrictions on Electronic Equipment*
DOC policy 1.3.D.2 – *Capital Punishment Housing*
DOC policy 1.5.D.1 -- *Inmate Visiting*
DOC policy 1.4.E.6 – *Management of Offender Deaths*

VI Revision Log:

August 2006: New policy.
June 2007: **Revised** the policy statement. **Revised** the definition of lethal injection. **Removed** medical doctors as witnesses required to be invited to the execution. **Deleted** references and

procedures related to SDCL § 23A-27A-38. **Revised** the post-execution procedures. **Moved** some information from the section on Media Relations and placed it in a new section titled The Execution. **Added** a reference to DOC policy 1.3.A.10. **Added** language about death penalty appeals. **Added** a statement regarding security measures. **Added** the circumstances in which an inmate may choose the current lethal injection procedures or revert back to existing law at the time of conviction or sentence. **Clarified** which individuals the victim's family may request as witnesses. **Added** a statement on the trained individuals' experience and qualifications. **Added** more specific procedures on administering the lethal dosages. **Added** a reference to *Taylor v. Crawford*.
August 2007: **Changed** "medical procedure" to "technical procedure" to avoid any possibility of confusion regarding an execution being considered the practice of medicine. **Updated** the procedures involving the county coroner in the section on The Execution.
June 2008: **Revised** formatting of policy in accordance with 1.1.A.2. **Changed** policy because of recent law changes to the capital punishment chapter, SDCL 23A-27A by the SD Legislature, 2008, SB 53 and the United States Supreme Court in **Baze v. Rees**, 553US 35, (2008). **Revised** definition of Lethal Injection. **Changed** "through" to "and" and "36" to "34-2" in definition of Witnesses. **Deleted** reference to DOH policy in subsection (ss) (A1), **revised** wording in ss (A2), **added** "each in a lethal quantity" in ss (A4), **deleted** comment about remaining unconscious in ss (A4a), **replaced** "person" with "inmate" in ss (5A and B), **added** comment about state statue and statute 32-1 in ss (5B), **replaced** "at least two (2)" to "one (1) or more" in ss (B2), **revised** section reading properly trained to read adequately trained and referenced court cases in ss (B2b), **clarified** on the information that is to remain confidential for those assisting with administering the intravenous injection in ss (b2c), **revised** wording of how inmates are housed and **replaced** statute 16 with 31.1 in ss (C1), **replaced** statute 16 with 31.1 in ss (C2), **added** that the Secretary of DOC and sentencing court will be notified regarding any question regarding an inmate's mental competence and **replaced** statement regarding a commission may be appointed with language from statute 22 through 26, and **replaced** statutes in ss (E) and **deleted** "/exaction" and "and/" in ss (I), of General Provisions section. **Revised** statement regarding sentencing judge in ss (A), **replaced** "delivered" with "provided in ss (A), **added** "Death Sentence and" to "Execution" regarding the certified Warrant in ss (A, B and C) and **added** statute 16 in ss (A and C) of Warrant of Execution section. **Replaced** "the witnesses" with "those" in ss (B), **revised** ss (C) to state no person will divulge within Time and Place of Execution section. **Added** statute 36 in ss (A), **replaced** "DOC staff, law enforcement officers" with "persons", **added** statute 32, 24-2, 36 and **replaced** 35 with 34.1 in ss (B), **deleted** former ss (B2), **replaced** "no more than ten (10)" with "a number of" in ss (C), **deleted** ss (C1), **moved** ss (C2) to above ss (C), **added** new ss (C1 and C2), **revised** wording regarding selection of witnessas in ss (D, D1, D2 and D2a), **deleted** former ss (D2c) regarding multiple victims, **deleted** "(Attorney General, trial judge, states attorney and sheriff)" in ss (E) and **added** ss (G) in Selection of Witnesses section. **Clarified** that no cameras or recording devices are allowed inside SDSP or area surrounding the execution chamber in ss (C) of Witness Behavior section. **Revised** wording in ss (A), **deleted** statement regarding photo requests of the execution chamber in ss (B) and **added** a new ss (C) regarding requests to take photos of the execution chamber, of the Media Relations section. **Deleted** statement regarding pursuant to SDCL 23A-27A-35 in ss (G) of Final Visit Arrangements section. **Revised** ss (D) to include two intravenous injection (IV) sites will be prepared and inserted, **added** "site" when referencing IV in ss (E), **added** "the transcript" in ss (H), **deleted** "to render the inmate unconscious" in ss (I), **replaced** "EMT" with "a person capable of examining" and **added** "for the presence of respirations and heartbeat and if appropriate" to ss (J), **deleted** statement about county coroner examining the inmate and **added** statement about taking charge of the body in ss (J2) and **deleted** statement regarding EMT and county coroner and **added** statement about death being pronounced ss (K) of The Execution section. **Replaced** "persons" with "witnesses", **deleted** statute 40, **added** statutes 34, 34.2, 40.1 in ss (A), **added** statute 24-1-27 in ss (B), **replaced** "declared" with "certified" in ss (B1) **added** statute 40.1 in ss (F) and **revised** bullets to read accordingly within the Post-Execution Procedures section. **Added** Baze v. Rees, 553 US 35, (2008), Taylor v. Crawford, 487 F. 3d 1072 (8th Cir., 2007) and DOC policy when referencing policies throughout policy. **Revised** other grammatical, spacing and sentence structure throughout policy.

July 2009: **Added** site code to Baze v Rees throughout policy. **Added** hyperlinks throughout policy. **Deleted** SDCL 23A-27A-30 in ss (G of General Provisions).
July 2010: **Revised** formatting of Section 1. **Replaced** SDSP with SD DOC in ss (A1 of General Provisions.
September 2011: **Reviewed with no changes.**
October 2011: **Deleted** "a" in IV.1.A. **Added** 3-Drug, 2-Drug, and 1-Drug protocol descriptions in Part IV.1.A.4. **Added** IV.1.B.1.c. **Moved** former IV.1.B.2.c. to IV.1.B.2.d. **Updated** Baze cites to published U.S. citation throughout. **Deleted** "Pancuronium Bromide and Potassium Chloride" from IV.8.I and **added** "For 3-Drug or 2-Drug protocol executions" and "subsequent drugs." **Deleted** "dosages of Sodium Pentathol, Pancuronium Bromide and Potassium Chloride" from IV.8.J. and **added** "injections."

Denny Kaemingk	*10/19/2011*
Denny Kaemingk, Secretary of Corrections	Date

STATE OF SOUTH DAKOTA) IN CIRCUIT COURT
:SS
COUNTY OF PENNINGTON) SEVENTH JUDICIAL CIRCUIT

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CHARLES RUSSELL RHINES, Petitioner, v. DOUGLAS WEBER, Warden, South Dakota State Penitentiary, Respondent	)	Civ. 02-924 FIRST AMENDED PETITION FOR WRIT OF HABEAS CORPUS AND COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

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Charles R. Rhines, for his First Amended Petition for Writ of Habeas Corpus and Complaint for Declaratory and Injunctive Relief states and alleges as follows:

1. Petitioner is currently in prison in the South Dakota Department of Corrections at Sioux Falls, SD. Petitioner is under a Judgment of Conviction entered in Circuit Court, Seventh Judicial Circuit, Pennington County, South Dakota. The Judgment of Conviction and Sentence of Death was entered on January 29, 1993. A copy of the Judgment was attached to Rhines' First Application for Writ of Habeas Corpus.

2. Charles R. Rhines appealed to the South Dakota Supreme Court, which affirmed his Conviction and Sentence of Death.

3. Charles R. Rhines filed a Petition for Writ of Certiorari, but the United States Supreme Court denied further review on December 2, 1996.

4. Charles R. Rhines applied for Writ of Habeas Corpus in State Court on December 5,

EXHIBIT
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1996.

5. Charles R. Rhines' Habeas Petition was denied by the Trial Court on October 8, 1998.

6. A Certificate of Probable Cause was granted, and the matter was appealed to the South Dakota Supreme Court.

7. The South Dakota Supreme Court affirmed the denial of the Petition for Writ of Habeas Corpus on February 9, 2000.

8. On February 22, 2000, Charles R. Rhines filed a Petition for Writ of Habeas Corpus in Federal District Court, District of South Dakota pursuant to 28 U.S.C. § 2254.

9. An Amended Petition for Writ of Habeas Corpus was filed on behalf of Charles R. Rhines on November 20, 2000.

10. The Respondent, Douglas Weber, alleged that several of the grounds raised by Charles R. Rhines in his Amended Petition for Writ of Habeas Corpus had not been exhausted and were, therefore, procedurally defaulted.

11. On July 3, 2002, the United States District Court, District of South Dakota, Western Division, found that Charles R. Rhines' grounds for relief numbers two (B), six (E), nine (B), (H), (I), and (J), twelve and thirteen were unexhausted.

12. The United States District Court for the District of South Dakota, Western Division, stayed the Petition pending exhaustion of Charles R. Rhines' State Court remedies on the condition that Rhines file a Petition for Habeas review in State Court within sixty (60) days and return to Federal Court within sixty (60) days of completing the State proceedings.

13. Respondent, Douglas Weber, appealed to the Eighth Circuit.

14. On direct appeal, the Eighth Circuit Court of Appeals vacated the stay and remanded the case to the United States District Court, District of South Dakota, Western Division, so that the District Court could determine whether Charles R. Rhines could proceed by dismissing the unexhausted claims from his Petition.

15. Charles R. Rhines filed a Petition for Writ of Certiorari with the United States Supreme Court to determine whether a District Court may issue an Order of Stay and Abeyance in a mixed petition for a Habeas Corpus Petition.

16. The United States Supreme Court held that the stay and abeyance procedure in a mixed petition for Petition for Writ of Habeas Corpus is permissible under certain circumstances. The case was remanded to the Eighth Court of Appeals so that it could determine whether the District Court abused its discretion in granting the stay and abeyance.

17. Because the District Court did not have the benefit of the controlling Supreme Court authority when it issued the Order of Stay and Abeyance in 2002, the Eighth Circuit Court of Appeals remanded the case to the District Court to analyze the Petition for Writ of Habeas Corpus under the tests enunciated in the United States Supreme Court case of Rhines v. Weber, 125 S. Ct. 1528, 161 LED 2nd 440, (2002).

18. Charles R. Rhines filed his initial Application for Writ of Habeas Corpus in the Circuit Court of South Dakota, Seventh Judicial Circuit, County of Pennington, on August 22, 2002.

19. On December 19, 2005, the United States District Court, the District of South Dakota, Western Division, entered its Order that the Petition for Habeas Corpus filed with the District Court was stayed pending exhaustion of various issues in State Court, conditioned upon the petition of returning to the District Court within thirty days of completing said exhaustion.

20. The officer by whom Charles R. Rhines is so imprisoned and so restrained is Douglas Weber, Warden of the South Dakota State Penitentiary.

GROUND ONE

21. The rights of Charles R. Rhines to due process, an impartial jury, and equal protection of the law were violated by exclusion for cause of the prospective juror Jack Meyer.

GROUND TWO

22. Charles R. Rhines' rights to due process, equal protection and to be free from cruel and unusual punishment were violated on account of the unconstitutionality of the South Dakota Capital Punishment Statutes in that the South Dakota Death Penalty Statutes in SDCL 23A-27A-1, mandate that the court "shall consider, or shall include in instructions to the jury" death penalty provisions "in all cases in for which the death penalty may be authorized," which is all Class A felonies under SDCL 22-6-1.

GROUND THREE

23. Charles R. Rhines' Fifth Amendment rights under the United States Constitution, and his corresponding rights under the South Dakota Constitution, including, but not limited to Article XI, Sections 7, 9, and 10, to due process of law, and the Sixth Amendment rights under the United States Constitution, and his corresponding rights under the South Dakota Constitution, including, but not limited to Article VI, Section 6 and 7, to assistance of counsel were violated through the ineffective assistance of his trial counsel. The ineffective assistance of trial counsel prejudiced Charles R. Rhines, and manifested itself in multiple ways including:

a. The tepid presentation of evidence during the penalty phrase by the attorneys for Mr. Rhines, including failure to contact or call available witnesses – including, but

not limited to John Fouske, James Mighell and Connie Royer – who would have provided helpful testimony for Mr. Rhines in the penalty phrase;

b. The failure to catch and correct onerous and false, highly prejudicial, testimony of Glen Wishard.

c. The failure to request the hiring of, consult with, or hire a mitigation consultant or expert.

d. The failure of trial counsel to register objections to keep out irrelevant prejudicial testimony such as Rhines having access to a gun, a statement by Rhines at the victim's funeral.

GROUND FOUR

24. The due process and equal protection rights of Charles R. Rhines under both the United States Constitution and the South Dakota Constitution were violated by various acts of prosecutorial misconduct. The prosecutor committed prosecutorial misconduct in, among other things, maintaining that the victim's hands were tied prior to the fatal wound, when the evidence was to the effect that they were tied afterwards; in referring to the victim being "gutted" in the assault when there was no such evidence; using and arguing from false and erroneous testimony from witness Glen Wishard; and using the improper tactic of eliminating all jurors with any misgivings about imposition or the death penalty.

GROUND FIVE

25. Charles R. Rhines was deprived his rights to due process of law, equal protection of the laws and the doctrine of separation of powers as provided by the state and federal constitutions in that the judgment and sentence of death resulted from a failure to follow the

procedure outlined in SDCL Ch. 23A – 27A. These violations are based on the following reasons:

a. Charles R. Rhines contends that the State's attorney has only the discretion to charge a Class A Felony, but that once such decision is made the punishment for any such offense lies solely within the province of the judicial branch.

b. SDCL Chapter 23A-27A has been applied unconstitutionally throughout the state in a manner so as to allow a state's attorney to charge under Ch. 23A – 27A, but also to allow the state's attorney the unfettered discretion, with no guidelines, whether to seek the death penalty.

c. Other persons who have been charged with Class A felonies have been allowed to enter into plea bargains in which state's attorneys have made promises of life imprisonment in return for a guilty plea to the Class A felony.

d. Under SDCL Ch 23A–27A, as interpreted, the jury may choose not to impose a death penalty even if aggravating circumstances are found for any reason or without any reason. Because of the discretion given to the jury under South Dakota's statutory scheme, selecting a jury that is "death qualified" skews the composition of the jury pool and eliminates from it those persons who are able to follow the circuit court's instructions but would nonetheless choose not to impose the death penalty.

e. Because the punishment that may be imposed for a Class A felony lies solely within the province of the judicial branch, the proper pool for proportionality analysis consists of all persons who entered guilty pleas or who were convicted of Class A felonies, regardless of whether the death penalty was imposed.

GROUND SIX

26. The South Dakota Supreme Court conducted its statutorily mandated proportionality review based only upon those cases in which a death penalty was imposed instead of all cases in which a death penalty might be imposed in violation of the terms of SDCL Ch 23A-27A, and deprived Charles R. Rhines of his rights to due process of law as provided by the state and federal constitutions.

GROUND SEVEN

27. The process by which Charles R. Rhines was charged, convicted and sentenced to death deprived him of his right to due process under the federal and state constitutions in that:

a. The death penalty under Chapter 23A-27A is a sentencing enhancement in all cases for which the death penalty may be authorized.

b. The due process clause of the Fifth Amendment and the notice and jury guarantee of the Sixth Amendment of the United States Constitution and the corresponding sections of the South Dakota Constitution require that any fact that increases the maximum penalty for a crime must be charged in an indictment, or, in the case of state actions, in an indictment or information.

c. The federal constitutional rights apply to Charles R. Rhines under the Fourteenth Amendment.

d. The aggravating circumstances under which Charles R. Rhines sentence of death was based were not alleged in the indictment or in any information.

GROUND EIGHT

28. The manner of execution as provided by SDCL 23A-27A-32 as in effect at the time of Charles R. Rhines conviction violates his rights to due process law and constitutes cruel and

unusual punishment under the Eighth Amendment of the United States Constitution and the corresponding Article under the South Dakota Constitution:

a. Executions are constitutional if they involve unnecessary and wanton infliction of pain or torture or lingering death.

b. Where pain is inflicted in an execution results from something more than the mere extinguishment of life, the United States Constitution Eighth Amendment and the corresponding South Dakota articles prohibition against cruel and unusual punishment are implicated.

c. Given the two chemicals specified in SDCL 23A-27A-32 in effect at the time of Charles R. Rhines' conviction and the absence of a person trained to administer and monitor anesthesia, it is reasonably foreseeable that Charles R. Rhines may experience suffocation and excruciating pain during his execution in violation of the Eighth Amendment and the corresponding South Dakota Amendment.

d. An execution pursuant to SDCL 23A-27A-23 as codified on the date of Charles R. Rhines' conviction violates the United States Constitution and the South Dakota Constitution prohibition against cruel and unusual punishment and is therefore unconstitutional.

GROUND NINE

29. That Charles R. Rhines' rights to due process of law and his rights to assistance of counsel under the United States Constitution and the South Dakota Constitution were further violated through the ineffective assistance of his trial counsel in that they failed to allege and argue as part of the direct appeal to the South Dakota Supreme Court the issues raised in grounds 1 through 8,inclusive, of this Petition, thereby prejudicing the Petitioner.

GROUND TEN

30. Charles R. Rhines' right to due process of law and his right to assistance of counsel guaranteed under the United States Constitution and the South Dakota Constitution were violated through the ineffective assistance of his habeas corpus counsel, in that counsel failed to raise the issues set forth in grounds 1 through 9, inclusive, of this Petition, in the Petition for Writ of Habeas Corpus initially filed, and the subsequent appeal to the South Dakota Supreme Court.

GROUND ELEVEN

31. The execution of Charles R. Rhines by lethal injunction as set forth in the present SDCL 23A-27A-32 violates Rhines' rights to due process under law and his rights against cruel and unusual punishment guaranteed under the United States Constitution and the South Dakota Constitution.

a. SDCL 23A-27A-32 was amended by the South Dakota Legislature during the 2007 legislature session.

b. On information and belief, the South Dakota Legislature rejected proposed amendments requiring executions be carried out in the most humane manner possible.

c. SDCL 23A-27A-32 removes the requirement of a physician participation in the execution process.

d. Executions are unconstitutional if they involve unnecessary and wanton infliction of pain or torture or lingering death.

e. Where pain is inflicted in an execution results from something more than the mere extinguishment of life, the constitutions of the United States and South Dakota. South Dakota Articles prohibition against cruel and unusual punishment are implicated.

32. Upon information and belief, the protocol presently in effect for lethal injection execution uses a three drug cocktail.

33. With the three drug cocktail presently believed to be used in executions, in the absence of a person trained to administer and monitor an anesthesia, it is reasonably foreseeable that Charles R. Rhines may experience suffocation and excruciating pain during his execution in violation of the Constitutions of the United States and South Dakota.

34. An execution pursuant to the present SDCL 23A-27A-32 violates the United States Constitution and the South Dakota Constitution's prohibition against cruel and unusual punishment and it is therefore unconstitutional.

GROUND TWELVE

35. Charles R. Rhines' right to due process of law against cruel and unusual punishment is guaranteed under the United States Constitution and the South Dakota Constitution is violated by the statutory procedure set forth in 23A-27A-32.

a. SDCL 23A-27A-32 was passed by the South Dakota legislature during the 2007 South Dakota legislative session.

b. SDCL 23a-27A-32 was amended in two specific areas: it removed the specifications of the two-drug cocktail to be used in the lethal injunction by the prior statute, and substituted in its place the requirement that the warden should determine the substances and the quantity of substances used for the punishment of death. The statute provided no other detail recording the warden's decision. The second change was that a physician was no longer required to participate in the execution process.

36. Executions are unconstitutional if they involve unnecessary and want an infliction of pain or torture or lingering death.

a. Pain inflicted in an execution results from something more than the mere extinguishment of life, the United States Constitution and the South Dakota Constitution is prohibition against cruel and unusual punishment is implicated.

b. An information and belief, the South Dakota legislature rejected proposed amendments requiring executions to be carried out in the most humane manner possible.

37. Given the fact that the warden is given no guidance as to the type of substances used or the quality of substances used for the punishment of death, and there is no requirement by law that the execution be carried out in a humane manner, and the absence of a person trained to administer and monitor an anesthesia, it is reasonably foreseeable that Charles R. Rhines may experience suffocation and excruciating pain during his execution, as allowed under the present statute.

38. An execution pursuant to the present SDCL 23A-27A-32 violates the United States Constitution and the South Dakota Constitution prohibition against cruel and unusual punishment and therefore is unconstitutional.

GROUND THIRTEEN

39. The present SDCL 23A-27A-32 constitutes an unconstitutional bill of attainder, and an unconstitutional ex post facto law as applied to Charles R. Rhines.

a. SDCL 23A-27A-32, as codified on the date of Charles R. Rhines' convictions is unconstitutional, for reasons previously stated.

b. SDCL 23A-27A-14 requires a condemned inmate to be sentenced to life in prison if the death penalty is declared unconstitutional.

c. Because Charles R. Rhines must be sentenced to life in prison as a result to the unconstitutionality of SDCL 23A-27A-32 as codified at the time of his conviction, and as a result of the application of SDCL 23A-27A-14, SDCL 23A-27A-32, as presently codified, constitutes an unconstitutional bill of attainder and an unconstitutional ex post fact law, as applied to Charles R. Rhines.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

1. Charles R. Rhines is presently incarcerated at the South Dakota Penitentiary. Defendant Douglas Weber is a resident of Sioux Falls, South Dakota and is employed by the State of South Dakota as a warden at the South Dakota State Penitentiary.

2. This is an action for declaratory and injunctive relief brought pursuant to the laws of the State of South Dakota.

3. This action is brought alternatively to Charles R. Rhines' Petition for Writ of Habeas Corpus.

4. The mandatory execution protocol provided by SDCL 23A-27A-32 as codified at the time of Charles R. Rhines' conviction required an intravenous injection by lethal quantity of an ultra short acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until convict was pronounced dead by a licensed physician according to the standards of medical practice.

5. SDCL 23A-27A-32 was amended by the South Dakota legislature during the 2007 South Dakota legislative session.

6. Given the two chemical specified in SDCL 23A-27A-32 in effect at the time Charles R. Rhines' conviction and the absence of a physician trained to administer and monitor an anesthesia, it is reasonable foreseeable that Charles R. Rhines may experience suffocation and

excruciating pain during his execution in violation of the constitutions of the United States and the State of South Dakota.

7. An execution pursuant to SDCL 23A-27A-32 as codified on the date of Charles R. Rhines' conviction violates the constitutions of the State of South Dakota and the United States prohibition against cruel and unusual punishment and is therefore unconstitutional.

8. SDCL 23A-27A-14 requires a condemned inmate be sentenced to life in prison if the death penalty is declared unconstitutional.

9. Because Charles R. Rhines must be sentenced to life in prison as a result of the application of SDCL 23A-27A-14, the present SDCL 23A-27A-32 constitutes an unconstitutional bill of attainder as applied to Charles R. Rhines.

10. Because Charles R. Rhines must be sentenced to life in prison as a result of the application of SDCL 23A-27A-14, the present SDCL 23A-27A-32 constitutes unconstitutional ex post facto laws as applied to Charles R. Rhines.

WHEREFORE, Petitioner Charles R. Rhines prays for the following relief:

1. That this court allow discovery and hold an evidentiary hearing on Petitioner's First Amended Petition for Writ of Habeas Corpus and Complaint for Declaratory Injective Relief;

2. An Order granting Petitioner relief on his First Amended Petition for Writ Habeas Corpus on any and all grounds 1 through 12 inclusive;

3. A declaration that a execution carried out by means of the two drug cocktail provided in SDCL 23A-27A-32 in effect at the time of Charles R. Rhines' conviction constitutes cruel and unusual punishment in violation of the constitutions of the State of South Dakota and the United States as well as depriving Rhines of his right to due process of law, and is therefore unconstitutional;

4. a declaration that because SDCL 23A-27A in effect at the time of Rhines' conviction is unconstitutional, that Charles R. Rhines must be sentenced to life in prison;

5. A declaration that SDCL 23A-27A-32, as presently codified, and as applied to Charles R. Rhines, constitutes an unconstitutional bill of attainder and an unconstitutional ex post facto law and deprives Rhines of his right to due process of the law;

6. An injunction requiring the State of South Dakota to sentence Charles R. Rhines to life in prison pursuant to SDCL 23A-27A-14; and

7. For such other and further relief as to the court seems just and appropriate.

Dated this 19th day of February, 2008.

Stuart, Gerry & Schlimgen, Prof. LLC:

By: _____

John A. Schlimgen
507 W. 10th Street
PO Box 966
Sioux Falls, SD 57101-0966
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Pennington County, SD
FILED
IN CIRCUIT COURT
FEB 21 2008
Renae Truman, Clerk of Courts
By_____ Deputy

X2

STATE OF SOUTH DAKOTA) IN CIRCUIT COURT
) SS
COUNTY OF PENNINGTON) SEVENTH JUDICIAL COURT
CIV. NO. 02-924

CHARLES RUSSELL RHINES,
Petitioner,

DOUGLAS WEBER, Warden,
South Dakota State
Penitentiary,
Respondent.

VIDEOTAPED DEPOSITION OF DR. MARK DERSHWITZ, taken before Kristin M. Stedman, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, at the Office of the Federal Public Defender, 51 Sleeper Street, 5th Floor, Boston, Massachusetts, on Monday, December 3, 2012, at 12:29 p.m.

KACZYNSKI REPORTING
72 CHANDLER STREET
BOSTON, MA 02116
(617) 426-6060

EXHIBIT
tabbies 3

APPEARANCES:
ON BEHALF OF THE PETITIONER:
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Districts of South Dakota and North Dakota
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(605) 224-0009
ON BEHALF OF THE RESPONDENT:
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Pierre, SD 57501-8501
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THE VIDEOGRAPHER:

STEVEN GARCIA
National Video Reporters, Inc.
7 Cedar Drive
Woburn, MA 01801
(781) 937-9900

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EXHIBITS

No.	Description	Page No.
None marked.		

PROCEEDINGS

THE VIDEOGRAPHER: We are now recording and on the record. My name is Steven Garcia. I am a legal video specialist for National Video Reporters, Inc. Our business address is 7 Cedar Drive, Woburn, Massachusetts, 01801.

Today is December 3, 2012, and the time is 12:29 p.m. This is the deposition of Dr. Mark Dershwitz in the matter of Charles Russell Rhines, plaintiff, versus Douglas Weber, defendant, in the Circuit Court, Seventh Judicial Court, State of South Dakota, County of Pennington, Civil Action Number 02-924.

This deposition is being taken at 51 Sleeper Street, Boston, Massachusetts on behalf of the plaintiff. The court reporter is Kristin M. Stedman of Kaczynski Court Reporting.

Counsel will state their appearances, and the court reporter will administer the oath.

MR. SWEDLUND: Paul Swedlund on behalf of the respondent.

MR. FULTON: Neil Fulton on behalf of the petitioner.

DR. MARK DERSHWITZ,
having first been satisfactorily identified and duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY MR. SWEDLUND:

Q. Could you state your name, please, for the record.

A. Mark Dershwitz.

Q. And, doctor, you are here today to provide expert testimony in the case of Rhines v. Weber, do you understand that?

A. Yes.

Q. And do you understand that all the answers that you give must be given to a reasonable degree of professional certainty for your profession?

A. Yes.

Q. Could you describe your qualifications for the court, your background and training that allows you to testify as an expert here in this case today?

A. Well, in college I have a bachelor's degree in chemistry, I then went to medical school at Northwestern University, and also obtained a Ph.D.

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pharmacology from Northwestern. I then did a residency in anesthesiology at Massachusetts General Hospital in Boston, followed by a research fellowship, and I have worked in academic anesthesiology since 1986, from 1986 through 2000 at Massachusetts General Hospital in Boston and Harvard Medical School, and since 2000, at the University of Massachusetts Medical School in Worcester.

Q. You mentioned the field of pharmacology, can you describe for the court what is that field?

A. Pharmacology is a basic medical science that, broadly speaking, studies the effects of chemicals on biological systems, and more specifically, the effects of drugs on human beings.

Q. And there are a couple of terms there, pharmacodynamics and pharmacokinetics, can you also describe those for the court?

A. Pharmacodynamics is the study of the mechanism of action of how drugs actually work, whereas pharmacokinetics is the time course of medications, how long does the drug actions last and how long does the drug last in the body.

Q. So dynamics would be the effect of the drug on a person and the kinetics would be the duration

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of the drugs?

A. Yes.

Q. Doctor, can you describe for the court your background as an expert witness in terms of the testimony that you have provided in cases either for the government or against the government?

A. Well, with regard to the cases involving lethal injection, I have been an expert on behalf of the, either the attorney general's office or the department of corrections in about a dozen and a half states.

Q. And while I am thinking about it, were you also an expert in the Baze case?

A. Yes.

Q. And for whom did you testify in Baze?

A. On behalf of the Commonwealth of Kentucky.

Q. Have you also at times outside of the context of lethal-injection protocols, testified on behalf of defendants in criminal cases?

A. There's been a couple of cases where I testified on behalf of defendants. The one that comes to mind is I was an expert on behalf of defendant Richard Reid, who was perhaps more commonly known as the Shoe Bomber.

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Q. And what was the nature of your testimony in that case?

A. The charges against him were that he tried to blow up a plane, and when the passengers realized what he was trying to do, they restrained him physically, and then some physicians on the plane opened up the medical kit on the plane and they gave him some sedating medications, including diazepam, which is more commonly known as Valium, and when the plane was diverted here to Boston, shortly after his arrest, he was interrogated and he confessed, and the question was whether or not somebody is capable of understanding their Miranda rights when they confess after being given a medication like diazepam, which produces what is called anterograde amnesia, which means amnesia for things that happen after the medication is given, and it was my belief that it was improper to accept a confession from somebody who had been medicated against his will with a medication that prohibited him from understanding his Miranda rights.

Q. So the Reid case involved both questions of dynamics and kinetics?

A. Correct.

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Q. Doctor, you have previously submitted affidavits in this case, one dated 18 September, 2012, and another dated 9 February, 2012, and I will show those to you briefly.

MR. FULTON: February and September?

MR. SWEDLUND: February and September, correct.

Q. Doctor, do those affidavits contain opinions that you have held about the protocol at issue in this case?

A. Yes.

Q. And are those opinions still current?

A. Yes.

Q. If you would please, doctor, could you explain the effects of 5 grams of pentobarbital administered as set forth in South Dakota's lethal injection protocol, what dynamic effect and what kinetic effect would that drug have?

A. First of all, from a kinetic point of view, when pentobarbital is injected intravenously, it has an onset of effect that is almost immediate. Within thirty to forty-five seconds after the drug reaches the brain, the person would be expected to lose consciousness.

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In addition, there are profound effects caused by pentobarbital on the circulatory system, and it's going to cause dilation of the blood vessels, which means relaxation of the blood vessels that is going to cause a reduction in blood pressure, and there's going to be effect on the heart to decrease the strength of the heart's ability to beat, so with a dose as large as 5000 milligrams or 5 grams, within a short period of time not only is the person as deeply unconscious as can be measured with the instruments that we have, that person's blood pressure is going to be extraordinarily low, possibly unmeasurable, and there will be extremely little, if any, circulation throughout the body.

Q. And in this unconscious state, can an inmate feel pain?

A. No.

Q. Why not?

A. In the level of anesthesia that 5000 milligrams of pentobarbital produces, this is actually a state much deeper than the state of surgical anesthesia that we anesthesiologists produce during anesthesia for surgical procedures.

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Q. So as the inmate goes into respiratory arrest, suffocates, the inmate is not feeling any pain?

A. Yeah, that is correct. So the pentobarbital will have this profound effect to decrease circulation, it will stop breathing typically within a minute or two of its administration, and the person will die due to the effects of decreased oxygen delivery to critical organs in the body, the heart and the brain, and there is a decreased delivery of oxygen, both because the person is not breathing and exchanging oxygen, as well as the fact that the circulation is depressed.

Q. Doctor, I have previously provided you with affidavits from the respondent in this case, Doug Weber, one dated the 22nd of October, 2012, the second dated 1st of November, 2012. I will show these to you, do you recognize those affidavits?

A. Yes.

Q. Have you reviewed them?

A. Yes.

Q. And can you describe for the court the outward physical, I guess behaviors exhibited by the two inmates at issue in those affidavits?

A. Well, to summerize what Warden Weber said was shortly after the drug was administered, the inmates took a last breath, typically a deep breath, and then were immobile.

Q. Did the inmates snore?

A. I think he said that there was one that took a, the last breath was like a snoring-type breath. Let me just -- in the case of Robert, his last breath he described as expelling a snore.

Q. Would a snore be consistent with the onset of unconsciousness?

A. It probably came afterward.

Q. And then, doctor, could you describe for the court, in your practice, have you seen instances where patients have their eyes open still after they have been administered anesthesia?

A. Yes, sometimes eyes remain open, even in a person who is deeply anesthestized, there may be mechanical reasons why the eyelids don't cover the eyes when the person loses consciousness, and as an anesthesiologist, since one of my responsibilities is to protect the eyes, I often tape or cover them during surgery in order to protect them.

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Q. What mechanical issues are you talking about might account for a patient not closing their eyes even though they are under anesthesia?

A. So when a person is lying on their back, gravity does not pull the eyelid down, and the residual muscle tone in both the muscles that raise the eyelid and lower the eyelid may be balanced in such a way that the eyelid does not cover the eye.

Q. If a patient, or in this case a condemned inmate's eyes are open, is that any indication that the patient is conscious and feeling pain?

A. Not at all.

Q. If an anesthetized patient, or in this case an inmate, a condemned inmate has, takes final deep breaths, or if one were to characterize those as gasps, would those be an indication that the inmate is experiencing pain?

A. No.

Q. Why not?

A. When somebody has drug-induced respiratory arrest, it is actually common that the last breath they take before becoming apneic, which is the cessation of ventilation, that last breath is very often a very deep one, and I see that regularly in

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you are using on a patient is pure, effective and sterile?
A. Yes.
Q. And again, your standard of care in your profession does not require you to go back behind the licensure and make sure that that licensing was validly given by the FDA before you would use a drug?
A. Well, I believe the pharmacies are not licensed by FDA, they're licensed by the state, but yes, I rely on the local authorities to make sure that the supply chain is indeed safe.
Q. That would be for the compounding pharmacist?
A. Yes.
Q. You rely on the state pharmacy board to properly license the pharmacist from whom you acquire your drugs?
A. Yes.
Q. And you rely on the FDA to properly license the drug manufacturer, suppliers from whom you receive your drugs?
A. Yes.
Q. Doctor, have you had an opportunity to

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review South Dakota's lethal infection protocol?
A. Yes.
Q. And I will provide you a copy. At least, I think I will. Where is my copy?
MR. FULTON: I have that one marked if you want to use it, Paul.
MR. SWEDLUND: Yes, if I could. Thank you. It's supposed to be right here.
Q. Do you have the protocol ERMA.12.8 before you?
A. Yes.
Q. And you reviewed that and you recognize it?
A. Yes.
Q. Do you have an opinion regarding whether ERMA.12.8 if performed as written would provide a painless and humane death for a condemned inmate in South Dakota?
A. It would.
Q. And what is it about the protocol that provides you the assurance that the inmate to whom the protocol is administered would experience a painless and humane death?
A. Does this apply to all versions of the --
Q. We're talking only about the one drug

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pentobarbital protocol.
A. Yeah, so with regard to the one-drug protocol with pentobarbital, the protocol simply states that 5000 milligrams will be injected, and after a period of time has elapsed, then the inmate will be examined for the presence of death.
Q. And does the protocol in your opinion provide sufficient assurance regarding the qualifications of the persons who will set and administer the drugs?
A. I believe so, although that is actually an area that is outside of my expertise in terms of vetting other individuals, but the fact that they are healthcare providers who do these procedures in their normal job is appropriate.
Q. So for example, the person who sets the IV line is an EMT by profession and currently certified and licensed, that person would in your opinion be capable of setting an IV line?
MR. FULTON: I would just before you answer, doctor, object to foundation given that he stated it's beyond his area of expertise. Sorry to interrupt him.
Q. Go ahead.

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A. I think in general when one considers the broad population of EMTs, many of them are trained to insert intravenous catheters. I have no specific knowledge of the person who may do it based upon this protocol.
Q. Okay. In the operation-room setting, who are the people that set an IV line for anesthesia?
A. It could be one of two or three populations of people, it could be the attending anesthesiologist, it could be the resident anesthesiologist or nurse anesthetist who is working under the direction of the anesthesiologist, or it could be a nurse who is preparing the patient before they're transported to the operating room.
Q. And while we have you here, doctor, if you could look at the two-drug protocol as well, and I assume that that would be administered using pentobarbital in a, combined with a paralytic agent; are your opinions the same as regards to the ability of South Dakota's two-drug protocol to provide a painless and humane death for an inmate?
A. Yes.
MR. SWEDLUND: I have nothing further.
THE WITNESS: Before we go on, could we

Seventh Judicial Circuit Court

PO Box 230
Rapid City SD 57709-0230
(605) 394-2571

CIRCUIT JUDGES
Jeff W. Davis
Wally Eklund
Janine M. Kern
Robert A. Mandel
Craig Pfeifle
Thomas L. Trimble

MAGISTRATE JUDGES
Scott M. Bogue
Heidi Linngren
Shawn J. Pahlke

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February 27, 2013

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Re: Decision (Civ. File 02-924)

Dear Counsel:

Enclosed please find my amended final decision in the Rhines' matter. Please prepare the appropriate findings of fact, objections and proposed Orders related to the decision.

Sincerely,

Thomas L. Trimble
Circuit Judge
Seventh Judicial Circuit

TLT*mvt

Pennington County, SD
FILED
IN CIRCUIT COURT
FEB 27 2013
Ranae Trumm, Clerk of Courts
By _____ Deputy



STATE OF SOUTH DAKOTA)) SS COUNTY OF PENNINGTON)	IN CIRCUIT COURT SEVENTH JUDICIAL CIRCUIT File No. Civ. 02-924
CHARLES RUSSELL RHINES Petitioner, **DOUGLAS WEBER,** Warden, South Dakota State Penitentiary, Respondent.	**AMENDED MEMORANDUM DECISION ON CHALLENGE TO SOUTH DAKOTA'S EXECUTION PROTOCOL AND ORDER**

I. PROCEDURAL AND FACTUAL BACKGROUND

The extensive procedural and factual background of this habeas petition was set forth in the Motion to Dismiss/Summary Judgment decision filed on September 17, 2012. Summary Judgment was denied as to Petitioner's Counts 8, 11 and 12. On December 18, 2012, a hearing was held for the purpose of receiving evidence as to those remaining claims. Both parties submitted exhibits including deposition testimony. Petitioner's objections to Exhibits 7R, 8R, 9R, 10R, and 25R are sustained. The admission of this evidence was not stipulated to by the parties nor was the information elicited from any witness. No live witnesses were called at the hearing. Most of the exhibits referenced in this decision are all sealed; therefore, references will be to the numbers/letters in the sealed court file. The issues remaining are:

Ground Eight:

¶28 The manner of execution as provided by SDCL 23A-27A-32 as in effect at the time Charles R. Rhines' conviction violated his rights to due process of law and constitutes cruel and unusual punishment under the Eighth Amendment of the United States Constitution and the corresponding Article under the South Dakota Constitution:

a. Executions are unconstitutional if they involve unnecessary and wanton infliction of pain or torture or lingering death.

b. Where pain is inflicted in an execution results from something more than the mere extinguishment of life, the United States Constitution Eighth Amendment and the corresponding South Dakota articles' prohibition against cruel and unusual punishment are implicated.

c. Given the two chemicals specified in SDCL 23A-27A-32 in effect at the time of Charles R. Rhines' conviction and the absence of a person trained to administer and monitor

anesthesia, it is reasonably foreseeable that Charles R. Rhines may experience suffocation and excruciating pain during his execution in violation of the Eighth Amendment and the corresponding South Dakota Amendment.

d. An execution pursuant to SDCL 23A-27A-23 as codified on the date of Charles R. Rhines' conviction violates the United States Constitution and the South Dakota Constitution prohibition against cruel and unusual punishment and is therefore unconstitutional.

Ground Eleven:

¶ 31 The execution of Charles R. Rhines by lethal injection as set forth in the present SDCL 23A-27A-32 violates Rhines' rights to due process under law and his rights against cruel and unusual punishment guaranteed under the United States Constitution and the South Dakota Constitution.

a. SDCL 23A-27A-32 was amended by the South Dakota Legislature during the 2007 legislative session.

b. On information and belief, the South Dakota Legislature rejected proposed amendments requiring executions be carried out in the most humane manner possible.

c. SDCL 23A-27A-32 removes the requirement of a physician participation in the execution process.

d. Executions are unconstitutional if they involve unnecessary and wanton infliction of pain or torture or lingering death.

e. Where pain inflicted in an execution results from something more than the mere extinguishment of life, the constitutions of the United States and South Dakota, South Dakota Articles prohibition against cruel and unusual punishment are implicated.

¶32 Upon information and belief, the protocol presently in effect for lethal injection execution uses a three drug cocktail.

¶33 With the three drug cocktail presently believed to be used in executions, in the absence of a person trained to administer and monitor an anesthesia, it is reasonably foreseeable that Charles R. Rhines may experience suffocation and excruciating pain during his execution in violation of the Constitutions of the United States and South Dakota.

¶34 An execution pursuant to the present SDCL 23A-27A-32 violates the United States Constitution and the South Dakota Constitution's prohibition against cruel and unusual punishment and it is therefore unconstitutional.

Ground Twelve:

¶35 Charles R. Rhines' right to due process of law against cruel and unusual punishment is guaranteed under the United States Constitution and the South Dakota Constitution is violated by the statutory procedure set forth in 23A-27A-32.

a. SDCL 23A-27A-32 was passed by the South Dakota legislature during the 2007 legislative session.

b. SDCL 23A-27A-32 was amended in two specific areas: it removed the specifications of the two drug cocktail to be used in the lethal injection by the prior statute, and substituted in its place the requirement that the Warden should determine the substances and the quantity of substances used for the punishment of death. The statute provided no other detail recording the Warden's decision. The second change was that a physician was no longer required to participate in the execution process.

¶36 Executions are unconstitutional if they involve unnecessary and wanton infliction of pain or torture or lingering death.

a. Pain inflicted in an execution results from something more than the mere extinguishment of life, the United States Constitution and the South Dakota Constitution is prohibition against cruel and unusual punishment is implicated.

b. On information and belief, the South Dakota legislature rejected proposed amendments requiring executions to be carried out in the most humane manner possible.

¶37 Given the fact that the Warden is given no guidance as to the type of substances used or the quality of substances used for the punishment of death, and there is no requirement by law that the execution be carried out in a humane manner, and the absence of a person trained to administer and monitor an anesthesia, it is reasonably foreseeable that Charles R. Rhines may experience suffocation and excruciating pain during his execution, as allowed under the present statute.

¶38 An execution pursuant to the present SDCL 23A-27A-32 violates the United States Constitution and the South Dakota Constitution prohibition against cruel and unusual punishment and therefore is unconstitutional.

Essentially, Petitioner's claims can be summarized into two issues. First, whether the lethal injection protocol adopted and implemented by the State of South Dakota complies with the mandates of the United States Supreme Court as set forth in the *Baze v. Rees* case? And, secondly, whether the lethal injection protocol violates Article VI, §23 of the South Dakota Constitution? The Petitioner's claims will be addressed separately below. All other issues raised by Petitioner in his Writ of Habeas Corpus have been addressed in the Memorandum Decision On Motion To Dismiss Or For Summary Judgment issued in September, 2012.

II. ANALYSIS

History of the Death Penalty and its application in South Dakota

Over South Dakota's history as both a territory and a state, 18 men have been executed. When South Dakota was first settled and was still Dakota Territory, hangings were the preferred method of execution. Between 1877 and 1915, 14 men were executed by hanging in South Dakota. See Dept. of Corrections, http://doc.sd.gov/about/faq/capitolpunishment.aspx. The first was Jack McCall, the killer of Wild Bill Hickok, who was hanged in 1877. While hanging was the most "universal method of execution" in the United States during this time, the Governor of New York commissioned a panel to find:

> the most humane and practical method known to modern science of carrying into effect the sentence of death,' " New York became the first State to authorize electrocution as a form of capital punishment. *Glass v. Louisiana*, 471 U.S. 1080, 1082, and n. 4, 105 S.Ct. 2159, 85 L.Ed.2d 514 (1985) (Brennan, J., dissenting from denial of certiorari); *Denno*, supra, at 373. By 1915, 11 other States had followed suit, motivated by the "well-grounded belief that electrocution is less painful and more humane than hanging." *Malloy v. South Carolina*, 237 U.S. 180, 185, 35 S.Ct. 507, 59 L.Ed. 905 (1915).

Baze v. Rees, 553 U.S. 35, 42, 128 S.Ct. 1520, 1526 (2008).

Executions by hanging continued in South Dakota until the death penalty was abolished in 1915. See, 1915 S.L. Ch. 158, H.B. 21. In 1933, the death penalty was reinstated and the electric chair became the sole method of execution. In 1947, George Sitts was convicted of murdering DCI agent Tom Matthews who was attempting to arrest Sitts on a fugitive warrant from Minnesota. He also killed Butte County Sheriff Dave Malcolm; however, he was first tried for Matthew's murder and after he was sentenced to death, the state did not try him for Malcolm's murder. See, *State v. Sitts*, 71 S.D. 494, 26 N.W.2d 187 (1947). He was the first and only person executed by electric chair in South Dakota.

In *Furman v. Georgia*, 408 U.S. 238, 92 S.Ct. 2726, 33 L.Ed.2d 346 (1972), the United States Supreme Court held a Georgia death penalty statute violated the 8th and 14th Amendments prohibiting cruel and unusual punishment:

> Petitioner in No. 69-5003 was convicted of murder in Georgia and was sentenced to death pursuant to Ga.Code Ann. s 26-1005 (Supp.1971) (effective prior to July 1, 1969). 225 Ga. 253, 167 S.E.2d 628 (1969). Petitioner in No. 69-5030 was convicted of rape in Georgia and was sentenced to death pursuant to Ga.Code Ann. s 26-1302 (Supp.1971) (effective prior to July 1, 1969). 225 Ga. 790, 171 S.E.2d 501 (1969). Petitioner in No. 69-5031 was convicted of rape in Texas and was sentenced to death pursuant to Vernon's Tex.Penal Code, Art. 1189 (1961). 447 S.W.2d 932 (Ct.Crim.App.1969). Certiorari was granted limited to the following question: '**Does the imposition and carrying out of the death penalty in (these cases) constitute cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments?**' 403 U.S. 952, 91 S.Ct. 2287, 29 L.Ed.2d 863 (1971). The Court holds that the imposition and carrying out of the death penalty in

> these cases constitute cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. The judgment in each case is therefore reversed insofar as it leaves undisturbed the death sentence imposed, and the cases are remanded for further proceedings. So ordered.

Id. (emphasis added.) The court issued a per curium decision which was less than one page long which reversed the imposition of the death penalty on the three consolidated cases. Justices Douglas, Brennan, Stewart, White and Marshall each wrote separate opinions in support of the judgments. Justices Blackmun, Powell and Renquist each filed separate dissents. The problem the Court had in the *Furman* case was that there were no standards for a jury to apply to the death penalty determination:

> Thus, these discretionary statutes are unconstitutional in their operation. They are pregnant with discrimination and discrimination is an ingredient not compatible with the idea of equal protection of the laws that is implicit in the ban on 'cruel and unusual' punishments.
>
> Any law which is nondiscriminatory on its face may be applied in such a way as to violate the Equal Protection Clause of the Fourteenth Amendment. *Yick Wo v. Hopkins*, 118 U.S. 356, 6 S.Ct. 1064, 30 L.Ed. 220. Such conceivably might be the fate of a mandatory death penalty, where equal or lesser sentences were imposed on the elite, a harsher one on the minorities or members of the lower castes. Whether a mandatory death penalty would otherwise be constitutional is a question I do not reach.

Furman v. Georgia, 408 U.S. 238, 257, 92 S.Ct. 2726, 2736 (Ga. 1972) Justice Douglas concurring.

This case led to a de facto nationwide moratorium on the death penalty for 9 years. See, *Baze v. Rees*, 553 U.S. 35, 42, 128 S.Ct. 1520, 1526. That moratorium ended with the United States Supreme Court's decision in *Gregg v. Georgia*. 428 U.S. 153, 96 S.Ct. 2909, 49 L.Ed.2d 859 (1976). *Id.* That decision held that the "statutory system under which Gregg was sentenced to death does not violate the Constitution." *Gregg*, 428 U.S. 207, 96 S.Ct. 2941. As a result of the *Gregg* case, state legislatures began reexamining electrocution as a "means of assuring a humane death." *Baze*, 553 U.S. 42, 128 S.Ct. 1526. In order to eliminate the issues the Court found in the *Furman* case, Georgia enacted a statutory scheme for the imposition of the death penalty. *Gregg*, 428 U.S. 161, 96 S.Ct. 2920. The trial was bifurcated into the guilt or innocence phase by either a judge or jury. *Id.* After a guilty verdict or finding, a presentence hearing was conducted before whoever made the guilt determination. *Id.*

> "(T)he judge (or jury) shall hear additional evidence in extenuation, mitigation, and aggravation of punishment, including the record of any prior criminal convictions and pleas of guilty or pleas of nolo contendere of the defendant, or the absence of any prior conviction and pleas: Provided, however, that only such evidence in aggravation as the State has made known to the defendant prior to his trial shall be admissible. The judge (or jury) shall also hear argument by the defendant or his counsel and the prosecuting attorney . . . regarding the punishment to be imposed." s 27-2503. (Supp.1975).

> The defendant is accorded substantial latitude as to the types of evidence that he may introduce. See *Brown v. State*, 235 Ga. 644, 647-650, 220 S.Ed.2d 922, 925-926 (1975). Evidence considered during the guilt stage may be considered during the sentencing stage without being resubmitted. *Eberheart v. State*, 232 Ga. 247, 253, 206 S.E.2d 12, 17 (1974).

Gregg, 428 U.S. 163-164, 96 S.Ct. 2920-21.

Furthermore, under the statutory scheme, the jury or court must have also found beyond a reasonable doubt, at least one aggravating circumstance as found in the statute. The statutory scheme also included an expedited direct review by the Georgia Supreme Court. If the Court affirmed the death sentence, then it was required to reference similar cases it took into consideration. *Gregg*, 428 U.S. 167, 96 S.Ct. 2922.

Interestingly, part of the Supreme Court's decision in *Gregg* looked at the history of the death penalty:

> It is clear from the foregoing precedents that the Eighth Amendment has not been regarded as a static concept. As Mr. Chief Justice Warren said, in an oft-quoted phrase, "(t)he Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society." *Trop v. Dulles*, Supra, 356 U.S. at 101, 78 S.Ct., at 598. See also *Jackson v. Bishop*, 404 F.2d 571, 579 (CA 8 1968). Cf. *Robinson v. California*, supra, 370 U.S., at 666, 82 S.Ct., at 1420. Thus, an assessment of contemporary values concerning the infliction of a challenged sanction is relevant to the application of the Eighth Amendment. As we develop below more fully, see Infra, at 2926-2927, this assessment does not call for a subjective judgment. It requires, rather, that we look to objective indicia that reflect the public attitude toward a given sanction.

Gregg, 428 U.S. 173, 96 S.Ct. 2925. The Court further examined the role of the judiciary in determining the constitutionality of a legislative enactment:

> But, while we have an obligation to insure that constitutional bounds are not overreached, we may not act as judges as we might as legislators.
>
> > "Courts are not representative bodies. They are not designed to be a good reflex of a democratic society. Their judgment is best informed, and therefore most dependable, within narrow limits. Their essential quality is detachment, founded on independence. History teaches that the independence of the judiciary is jeopardized when courts become embroiled in the passions of the day and assume primary responsibility in choosing between competing political, economic and social pressures." *Dennis v. United States*, 341 U.S. 494, 525, 71 S.Ct. 857, 875, 95 L.Ed. 1137 (1951) (Frankfurter, J., concurring in affirmance of judgment).
>
> Therefore, in assessing a punishment selected by a democratically elected legislature against the constitutional measure, we presume its validity. We may not require the legislature to select the least severe penalty possible so long as the penalty selected is not

cruelly inhumane or disproportionate to the crime involved. And a heavy burden rests on those who would attack the judgment of the representatives of the people.

Gregg, 428 U.S. 175, 96 S.Ct. 2926.

Ultimately, the *Gregg* court upheld Georgia's death penalty statutes:

In summary, the concerns expressed in *Furman* that the penalty of death not be imposed in an arbitrary or capricious manner can be met by a carefully drafted statute that ensures that the sentencing authority is given adequate information and guidance. As a general proposition these concerns are best met by a system that provides for a bifurcated proceeding at which the sentencing authority is apprised of the information relevant to the imposition of sentence and provided with standards to guide its use of the information.

Gregg, 428 U.S. 195, 96 S.Ct. 2935.

Following the *Gregg* decision, a new version of the death penalty was enacted in South Dakota in 1979. See 1979 SB 53; see former SDCL 22-6-1 (1979); SDCL 22-16-9 (1979). SDCL 22-19-1 (1979). This statutory scheme embraced the dictates of *Gregg* and provided for aggravating circumstances, a mitigation hearing, an expedited direct review and a proportionality review of the sentence. No one in South Dakota was executed between the 1947 electrocution of Sitts and the 2007 execution of Elijah Page by lethal injection.

The South Dakota legislature amended SDCL 23A-27A-32 in 2007 to provide for execution "by the intravenous injection of a substance or substances in a lethal quantity." The statute instructed the "Warden, subject to the approval of the secretary of corrections, [to] determine the substances and quantity of substances used for the punishment of death." SDCL 23A-27A-32.

Per the directives given to him by SDCL 23A-27A-32, the Warden promulgated a policy effective June 14, 2007, providing for execution by: (1) "Sodium Pentothal, (aka Sodium Thiopental)...in a quantity sufficient to ensure the inmate is and remains unconscious and is not subjected to the unnecessary and wanton infliction of pain;" (2) Pancuronium Bromide to stop the inmate's breathing, and; (3) Potassium Chloride to stop the inmate's heart. See Exhibit 3.

Subsequent to formulating the June 14, 2007, protocol, the United States Supreme Court's *Baze* decision detailed the safeguards the court deemed constitutionally sufficient to protect condemned inmates from anesthetic maladministration. *Baze v. Rees*, 553 U.S. 54-61, 128 S.Ct. 1533-1538. As a result, the Warden consulted with legal counsel to determine what changes should be made to the June 2007 policy. The DOC revised the policy in August 2010 to incorporate further safeguards against anesthetic maladministration mandated by *Baze*. See Weber Affidavit, Exhibit 3R, ¶¶ 6-8. The revised protocol called for execution by the same three chemicals as originally specified in the June 14, 2007, protocol, but with newly specified dosages. *Id.* at ¶8.

In response to emerging judicial acceptance of pentobarbital as an execution anesthetic, the Warden again modified the protocol in October of 2011 to provide for execution via a one-drug, pentobarbital protocol for all prospective executions. Id. at ¶9. South Dakota has now joined Ohio, Washington, Idaho, Oklahoma and Pennsylvania with having a one drug protocol. While the October 13, 2011, protocol retains three and two drug options utilizing sodium thiopental, those exist as backup procedures should future circumstances require DOC to revert to those earlier procedures.

After the executions of Eric Robert and Donald Moeller in October 2012, the Warden modified the protocol slightly to provide inmates with express assurance that any compounded execution drugs would be prepared according to the governing standards of the United States Pharmacopeia. The November 2012 protocol retains *Baze's* safeguards for the proper administration of the anesthetic. See Exhibit 2R.

Issue One

Whether Petitioner's challenge to the lethal injection protocol adopted and implemented by the State of South Dakota as set forth in detail in Petitioner's Habeas Petition Grounds 8, 11 and 12, complies with the mandates of the United States Supreme Court as set forth in the *Baze v. Rees* and the Eighth Amendment to the United States Constitution?

A. *Baze v. Rees* and Substantial Risk of Serious Harm and Suffering

Petitioner claims that the lethal injection protocol adopted and implemented by South Dakota "does not adequately guard against substantial risk of serious harm and suffering." See Petitioner's Pretrial Brief, p. 1. Petitioner further argues that South Dakota has not "chosen individuals to carry out the execution who have adequate and appropriate training and experience to guard against that risk." *Id.*

Like *Baze*, where the United States Supreme Court addressed whether Kentucky's three-drug lethal injection method of capital punishment posed an unacceptable risk of significant pain and was cruel and unusual punishment under the Eighth Amendment, Rhines' argument centers on the risk of serious harm and suffering. *Baze v. Rees*, 553 U.S. 35, 128 S.Ct. 1520 (2008). Ultimately, the Court held that Kentucky's method of capital punishment satisfied the Eighth Amendment:

> The Eighth Amendment to the Constitution, applicable to the States through the Due Process Clause of the Fourteenth Amendment, see *Robinson v. California*, 370 U.S. 660, 666, 82 S.Ct. 1417, 8 L.Ed.2d 758 (1962), provides that "[e]xcessive bail shall not be required, nor excessive fines imposed, **nor cruel and unusual punishments inflicted.**" We begin with the principle, settled by *Gregg*, that capital punishment is constitutional. See 428 U.S., at 177, 96 S.Ct. 2909 (joint opinion of Stewart, Powell, and STEVENS, JJ.). It necessarily follows that there must be a means of carrying it out. Some risk of pain is inherent in any method of execution—no matter how humane—if only from the

> prospect of error in following the required procedure. It is clear, then, that the Constitution does not demand the avoidance of all risk of pain in carrying out executions.

(emphasis added), Id., 553 U.S. 47, 128 S.Ct. 1529. Thus, Rhines does not challenge lethal injection per se. Rather, the challenge is to the protocol and the manner in which the execution is carried out. Petitioner argues that there is a significant risk that the drugs will not be properly administered which will lead to severe pain when the other chemicals are administered and therefore, the possibility of improper administration of the drugs would be violative of the Eighth Amendment. However, the Supreme Court has held that in order to prevail on a claim of cruel and unusual punishment there must be "substantial risk of serious harm":

> To establish that such exposure violates the Eighth Amendment, however, the conditions presenting the risk must be "sure or very likely to cause serious illness and needless suffering," and give rise to "sufficiently imminent dangers." *Helling v. McKinney*, 509 U.S. 25, 33, 34–35, 113 S.Ct. 2475, 125 L.Ed.2d 22 (1993) (emphasis added). We have explained that to prevail on such a claim there must be a "substantial risk of serious harm," an "objectively intolerable risk of harm" that prevents prison officials from pleading that they were "subjectively blameless for purposes of the Eighth Amendment." *Farmer v. Brennan*, 511 U.S. 825, 842, 846, and n. 9, 114 S.Ct. 1970, 128 L.Ed.2d 811 (1994).

Baze v. Rees, 553 U.S. 49-50, 128 S.Ct. 1530-31. The Court further explained that "simply because an execution method may result in pain....does not establish the sort of 'objectively intolerable risk of harm' that qualifies as cruel and unusual." *Id.* It is important to note that following *Baze*, no federal appellate court has invalidated a lethal injection protocol under the Eighth Amendment. *Cooey v. Strickland*, 589 F.3d 210, 221 (6th Cir. 2009); *Nooner v. Norris*, 594 F.3d 592, 596 (8th Cir. 2010); *Clemens v. Crawford*, 585 F.3d 1119, 1124 (8th Cir. 2007).

The *Cooey* court explained in detail what Baze does not require:

> In thinking about what Baze requires, it is helpful to remember what it does not. The opinion contains several controlling premises within which Biros must formulate his challenge: Capital punishment is constitutional, see id. at 1529; death-row inmates cannot use method-of-execution challenges to prohibit what the Constitution allows, id.; "the Constitution does not demand" a pain-free execution, id. at 1529, 1537; and an inmate cannot question a state's execution protocol without providing "feasible, readily implemented" alternatives that " significantly reduce a substantial risk of severe pain," see id. at 1532 (emphasis added); id. at 1531 ("[A] condemned prisoner cannot successfully challenge a State's method of execution merely by showing a slightly or marginally safer alternative."). Significantly, the Constitution does not allow the federal courts to act as a best-practices board empowered to demand that states adopt the least risky execution protocol possible. See id. at 1529, 1531. Within this framework, the Supreme Court has never held that an inmate met the "heavy burden" of demonstrating that a state's execution protocol is "cruelly inhumane" in violation of the Constitution. See id. at 1533 (citing *Gregg*, 428 U.S. at 175, 96 S.Ct. 2909); see also id. at 1529, 1531; *Harbison*, 571 F.3d at 535 (rejecting a challenge to Tennessee's lethal injection protocol after *Baze*).

With these standards in mind, the next step is to compare the *Baze* requirements with South Dakota's protocol to determine whether they are substantially similar and thus, constitutional.

B. South Dakota's Lethal Injection Protocol is Substantially Similar to *Baze* and is Constitutional on its Face

After *Baze* was decided by the United States Supreme Court in 2008, South Dakota's Warden consulted with legal counsel to determine what changes, if any, should be made to South Dakota's existing protocol in order for it to be compliant with the mandates of *Baze*. Department of Corrections revised its existing protocol in August 2010. Weber Protocol Affidavit, Exhibit 3R, ¶¶ 11-14. This revised protocol used the same three-drug protocol approved in *Baze*. In response to emerging judicial acceptance of pentobarbital as an execution anesthetic, South Dakota's Warden again modified the protocol in October of 2011 to provide for execution via a one-drug, pentobarbital protocol for all prospective executions. Exhibit 2R, ERM A.12(B)(H), Weber Protocol Affidavit, Exhibit 3R, ¶14. At that time, South Dakota joined Ohio and Washington in moving to a one-drug protocol. Since then, Idaho, Oklahoma, and Pennsylvania have also adopted a one-drug, pentobarbital protocol.

After the executions of Eric Robert and Donald Moeller in October, 2012, the South Dakota Warden modified the protocol slightly to provide inmates with express assurance that any compounded execution drugs would be prepared according to the governing standards of the United States Pharmacopeia. The November 2012 protocol retains *Baze's* safeguards for the proper administration of the anesthetic. Exhibit 2R, ERM A.12(B)(D)(1). Those are:

1. The execution is performed under the oversight and command of the Warden, who, by statute and policy is charged with numerous duties to ensure a humane execution. Exhibit 3R, Weber Protocol Affidavit, ¶ 2.

2. The Warden assures that two complete sets of pentobarbital syringes are prepared for the execution. Exhibit 3R, Exhibit 2R, ERM A.12(B)(A)(3).

3. Ambulance staff equipped with advanced life support capabilities, including a heart defibrillator and such supplies and equipment as would be needed to attempt to revive an individual who has been injected with pentobarbital shall be on standby at the SDSP. Exhibit 3R, Exhibit 2R, ERM A.12(B)(A)(5).

4. Execution team members must be qualified to carry out their functions. Persons responsible for inserting the needles and establishing IV lines must be "trained to perform venipuncture and to administer intravenous injections." To meet qualifications, the persons who "connect, monitor, and maintain intravenous lines" must be "certified or licensed and have at least two (2) years professional experience" as one of the following: "medical or osteopathic physician, physician assistant, registered nurse, certified medical assistant, licensed practical

nurse, phlebotomist, paramedic, emergency medical technical, or military corpsman." Exhibit 2R, ERM A.12(B)(B)(1)(3).

5. The person responsible for mixing the drugs, preparing the syringes, and administering the injections must "demonstrate proficiency through relevant training and two years' experience in the administration of drugs by intravenous injection; preparation of syringes for such administration; and mixing and preparing of drugs for such administration." Exhibit 2R, ERM A.12(B)(B)(2).

6. The two sets of chemicals are labeled and contained in numbered syringes. Exhibit 2R, ERM A.12(B)(C)(1).

7. The pentobarbital is mixed or prepared in accordance with USP 797 and is thereafter maintained in accordance with manufacturer's instructions. The pentobarbital must be mixed or prepared in bright, undimmed light. Exhibit 2R, ERM A.12(B)(D)(3); Exhibit 4R, at ¶¶6, 9, 11; Exhibit 5R, Deponent #1 Affidavit at ¶1, Exhibit 3R, Weber Protocol Affidavit, at ¶ 9.

8. DOC staff responsible for performing the execution is required to "drill at least weekly for six to eight weeks prior to the scheduled date of execution," as well as to perform "additional drills the week of the scheduled execution" at the Warden's direction. Exhibit 2R, ERM A.12(B)(D)(1).

9. At least one week prior to the execution, a medical provider examines the inmate and prepares a report "describing the inmate's physical condition and any medical condition of the inmate that may lead to potential problems establishing the IV site." Exhibit 2R, ERM A.12(B)(D)(2).

10. The protocol requires that every effort be made to ensure that no unnecessary pain is inflicted on the inmate. Exhibit 2R, ERM A.12(B)(D)(10).

11. The inmate is secured to the execution gurney in such a position that "at all times" his "head and face are visible to the Warden and to those in the chemical room." Exhibit 2R, ERM A.12(B)(D)(9).

12. The IV team shall establish "two independent IV lines to the inmate's veins. The IV team will establish IV lines only in peripheral veins located in the inmate's arms, hands, legs or feet, preferably one in each arm." Exhibit 2R, ERM A.12(B)(D)(8). The lines must be secured "in such a way as to leave them visible for monitoring."

13. If the IV team "cannot secure one (1) or more sites within one (1) hour," the execution will cease and a request shall be made that the execution be "scheduled for a later date during the week of the execution." Exhibit 2R, ERM A.12(B)(D)(11).

14. The IV team will "start a saline flow and a sufficient quantity of saline solution shall be injected to confirm that the IV lines have been properly inserted and are not obstructed." Exhibit 2R, ERM A.12(B)(D)(12).

15. The Warden stands in the execution chamber with the condemned and issues the order for the execution to proceed from there. Exhibit 2R, ERM A.12(B)(E)(2).

16. The executioner then administers syringe #1 containing 2.5 grams of pentobarbital in a 50 cc solution followed by syringe #2 containing 2.5 grams of pentobarbital in a 50 cc solution followed by syringe # 3 containing 25 ml. of normal saline. Exhibit 2R, ERM A.12(B)(C)(3); ERM A.12(B)(H)(4)-(6).

17. The person responsible for pronouncing death monitors the IV lines and the inmate's response to the injection over the next 15 minutes. If the person responsible for pronouncing death is not able to do so after 15 minutes, "the Warden shall order a second set of chemicals to be administered." Exhibit 2R, ERM A.12(B)(H)(7).

18. Ten minutes after the second round of the drug is administered, "[t]he person responsible for pronouncing death shall enter the chamber and confirm death by checking the inmate's heartbeat, breathing, pulse, and pupils." Exhibit 2R, ERM A.12(B)(H)(10).

ERM A.12(B), compare with *Baze*, 553 U.S. at 44-46, 51, 55-56, 128 S.Ct. at 1528, 1531, 1533-34 and *Baze* Protocol, Exhibit 2R, ERM A.12(B).

A comparison of South Dakota's ERM A.12(B) protocol with the *Baze* decision reveals that South Dakota's lethal injection protocol is "substantially similar" to, and in many respects more protective than Kentucky's as set forth in *Baze* and is therefore, constitutional on its face. *Id.* Petitioner has failed to show that the lethal injection protocol adopted by South Dakota "does not adequately guard against substantial risk of serious harm and suffering." Consequently, Rhines' argument set forth in Grounds 8, 11 and 12 that the lethal injection protocol adopted by South Dakota is unconstitutional and violates the 8th Amendment of the United States must fail.

C.

South Dakota Implements its Protocol in a Constitutional Manner

Rhine's also argues in Grounds 8, 11 and 12 of the habeas petition that the manner in which the lethal injection protocol is implemented is unconstitutional. More specifically, Rhines argues:

1) the execution team member known as Witness #3 does not have adequate training and experience to administer the lethal injection protocol; and

2) that execution team member Witness #3 does not have adequate experience and is not placed properly in the execution chamber, to recognize infiltration of the IV line which can result in reduced efficacy of the IV; and

3) that execution team member Witness #3 does not have proper experience and placement to ensure that the IV line is properly set at the outset, to monitor the IV lines in operation, or to place a central line in, if needed, and as called for under the protocol; and

4) that execution team member Witness #2 is charged with administering the lethal injection from a control room separated from the execution chamber; and

5) that execution team member Witness #2 has limited experience in administration of intravenous drugs; and

6) that execution team member Witness #2 lacks the training and experience to recognize if drugs are being taken up by the body in a proper fashion, to monitor the effect of the drugs, to recognize a proper administration rate or to understand the proper handling and administration of barbiturates like pentobarbital; and

7) that the compounded drug in not reliably pure and potent; and

8) that the execution protocol does not guarantee adequate medical monitoring and does not require that individuals with adequate training or experience select the members of the team; and

9) that the protocol creates a system that impermissibly increases the risk of error or mishap which can result in a cruel and unusual execution.

See Petitioner's Pretrial Brief, p. 1-2. Each of these arguments will be addressed below.

i. Witness #3
IV Setter

Witness #3 (also referred to as Deponent #3) is the person responsible for setting the IV lines. ERM A.12(B)(3) describes the qualifications:

> The person(s) selected by the Warden to insert the intravenous needles into the veins of the prisoner and connect, monitor, and maintain intravenous lines shall be certified or licensed and have at least two (2) years' professional experience as one of the following: medical or osteopathic physician, physician assistant, registered nurse, certified medical assistant, licensed practical nurse, phlebotomist, paramedic, emergency medical technician, or military corpsman.

These qualifications are consistent with, and even exceed, those set forth in *Baze*. *Baze* approved Kentucky's requirement that the IV setter have one year of professional experience as an EMT. *Baze*, 553 U.S. at 55, 128 S.Ct. at 1533. Kentucky met this requirement by employing an EMT who had "daily experience establishing IV lines for inmates," but neither the Kentucky protocol nor the *Baze* decision require "daily" experience.

Witness #3 who was part of the execution team for the Page, Robert and Moeller executions has a bachelor's degree in health education. Exhibit I at p. 8, line 12. Prior to obtaining his bachelor's degree, he received two years of paramedic training from an accredited institution. Exhibit I at p. 10, lines 3-11. That training included setting IV lines and administering IV drugs. Exhibit I at p. 10, line 15; p. 11, line 2. Witness #3 also worked for 15 years as a field supervisor and response medic on an ambulance. Exhibit I at p. 12, line 11. He then worked as an ambulance response medic before assuming supervisory duties. Exhibit I p. 12, line 19; p. 13, line 6. As part of his job, he is required to go on ambulance calls and to maintain his paramedic certification. Exhibit I at p. 15, line 20.

Witness #3 has been a state certified paramedic for 29 years. Exhibit I at p. 14, line 20, p. 15, line 3, p. 106, line 4. During that time, he has set thousands of IV lines. Exhibit I at p. 106, line 4. He has also participated in numerous executions. Exhibit I at p. 44, line 14. Witness #3 testified that he has never had a complication arise during an execution. Exhibit I at p. 41, line 15. He is also trained to recognize signs of IV malfunctioning, such as swelling, leaking, or discoloration in the lines. Exhibit I at p. 77, line 7; p. 86, lines 10-21; p. 87, line 14-88, 25; p. 89, lines 15-25; p. 100, line 7. If an IV line was malfunctioning, Witness #3 testified that he would switch to the secondary line or start a new one. Exhibit I at p. 81, line 12; p.87, line 4. Witness #3 stated that in the executions he has participated in, the inmate very quickly becomes lethargic, goes unconscious, takes some labored respirations, then goes into respiratory arrest. Exhibit I at p. 45, line 21; p.101, line 24. Signs of respiratory arrest are no chest wall movement and no air way sounds. Exhibit I at p. 46, line 7.

Witness #3 clearly is qualified under ERM A.12(B)(3) and the *Baze* decision. Thus, Rhines' arguments that Witness #3 does not have adequate training and experience to administer the lethal injection protocol, does not have adequate experience to recognize infiltration of the IV line and that Witness #3 does not have proper experience and placement to ensure that the IV line is properly set at the outset, to monitor the IV lines in operation, or to place a central line if, if needed, and as called for under the protocol are all without merit.

ii. Witness #2
Drug Administer

Witness #2 is the person responsible for administering the injections. ERM A.12(B)(4) provides:

> The person(s) selected by the Warden to administer the injections shall demonstrate proficiency through relevant training and two years' experience in the administration of drugs by intravenous injection.

Again, as with Witness #3, the qualifications required of Witness #2 are consistent with *Baze*. Witness #2 testified that approximately 11 years ago, he began several months of training to administer lethal injection drugs. Exhibit H at p. 18, line 12; p. 19, line 8. Witness #2 received his training from a fellow correctional officer who was experienced in performing lethal injections. Exhibit H at p. 18, line 24. He observed several executions before participating in one. Exhibit H at p. 48, line 10. Since first participating in an execution more than ten years

ago, he has performed numerous executions without complication, including executions using pentobarbital. Exhibit H at p. 112, line 5; p.20, line 1; p. 36, line 8; p. 103, line 13.

When performing an execution, Witness #2 consults the protocol to learn the drugs which will be used and the concentration. Exhibit H at p. 29, line 22. He checks the drug labels and compares them with the protocol to ensure that he has the correct drugs. Exhibit H at p. 30, line 2; p. 30, line 19. He testified he would not administer a drug that was not in the protocol. Exhibit H at p. 77, line 10; p. 93, line 14. He inspects the condition of the drugs to be administered to make sure they have been stored properly (temperature, sealed, appearance) and also checks the seals on the syringes and IV tubes. Exhibit H at p. 25, line 7; p. 70, line 13; p. 71, line 14; p. 86, line 9. He is also trained to detect catheter site swelling and back pressure on syringes that would suggest poor flow. Exhibit H at p. 105, line 14; p. 106, line 5; p. 106, line 15; p. 107, line 4, 20.

Each time he has administered pentobarbital, Witness #2 has observed no signs that an inmate experienced pain. Exhibit H at p. 83, line 17. He expects to participate in drills prior to performing an execution in South Dakota. Exhibit H at p. 83, line 17.

Witness #2 clearly is qualified under ERM A.12(B)(4) and the *Baze* decision. Rhines' arguments that execution team member Witness #2 is inexperienced and lacks training to recognize if drugs are being taken up by the body in a proper fashion, to monitor the effect of the drugs, to recognize a proper administration rate or to understand the proper handling and administration of barbiturates like pentobarbital are unfounded.

Drug Compounding and Pharmacist Qualifications

Rhines argues that the compounded drug is not reliably pure and potent and therefore, the administration of the protocol poses a substantial risk of severe pain to the inmate. He also argues that the pharmacist is incompetent to compound pentobarbital.

iii. Drug Compounding

At the December hearing, Rhines introduced the trial deposition of Dr. Mark Heath who testified that he was not a pharmacist and that he did not have a high level of expertise in the mechanics of compounding. Trial Exhibit 9 at p. 14, lines 16-25; p. 15, lines 2-6. He stated that his opinions were related to the effect the drug would have if compounded incorrectly. Trial Exhibit 9 at p. 15, line 18. He went on to explain the areas where he believes errors could occur:

> In a broad level I think there are two main areas that things can go wrong. One would be that there's a chemical accidentally or inadvertently introduced or formed in the material that could cause an undesired reaction or response, in other words, having an extra thing that sound [sic] shouldn't be there. And the other realm of problem is that should happen to degrade the drug, the pentobarbital that is there so that the amount there is inadequate.

Trial Exhibit 9 at p. 16, lines 3-12. When asked specifically about whether South Dakota's protocol for implementing lethal injection posed a "substantial risk of severe pain to an individual," Dr. Heath testified as follows:

> But to clarify, when I talk about a substantial risk, it factored in several things, also the likelihood of it happening and also the gravity or severity of the event were it to occur and also how easily it is to obviate or eliminate the risk. So it's a factor of things, a mix of things. And in this instance, there's a risk of terrible thing [sic] happening. I think everybody would agree that nobody wants the prisoner to end up brain damaged. They wouldn't—probably wouldn't even execute them if that the outcome of an attempted execution. It's unlikely, but it's a terrible thing to have happen, and nothing is a hundred percent preventable. It's more preventable than it currently is. In those terms I would say, it's a substantial risk—unlikely, severe, preventable.

The trial court has great discretion when it comes to the weight to be given to any witness' testimony. Dr. Heath's does not give any testimony regarding the actual compounding of the pentobarbital but rather focuses on the physiological effects that could occur if the drug was compounded incorrectly. But as is shown in his testimony quoted above, he testified that the risk was unlikely.

> We have often said that fact finders are not required to accept an expert's opinion. As with all witnesses, it falls on the trier of fact to decide whether to believe all, part, or none of an expert's testimony. *Sauer v. Tiffany Laundry & Dry Cleaners*, 2001 SD 24, ¶ 14, 622 N.W.2d 741, 745 (citations omitted); *Lewton v. McCauley*, 460 N.W.2d 728, 732 (S.D.1990) (citation omitted).

Great Western Bank v. H & E Enterprises, LLP, 2007 S.D. 38, 731 N.W.2d 207. This court does not find Dr. Heath's testimony on whether South Dakota's protocol for implementing lethal injection poses a "substantial risk of severe pain to an individual" to be relevant or useful.

Rhines also relies on the Declaration of Dr. Sarah Sellers who was an expert in the Donald Moeller case. Dr. Sellers is the executive director and consultant for Q-Vigilance, LLC. See Trial Exhibits 1 and 2. She stated that her work focuses on the public health risks of drug compounding. In her opinion, "this pentobarbital sodium API formulated under the indicated ...recipe cannot be used for compounding as doing so would result in risk of serious harm to Mr. Moeller." See Trial Exhibit 2, p. 15, ¶ 5. She did not testify live at Rhines' hearing.

In contrast to Dr. Sellers' testimony, Respondent introduced the trial deposition of Dr. Mark Dershwitz. See Exhibit 26R0. Dr. Dershwitz has a bachelor's degree in chemistry, went to medical school at Northwestern University and also obtained a Ph.D. in pharmacology. Exhibit 26R at p.5, lines 22-24; p. 6, line 1. He did his residency in anesthesiology followed by a research fellowship and he worked in academic anesthesiology since 1986 teaching at Massachusetts General Hospital, Harvard Medical School and Massachusetts Medical School. When asked about the practice of compounding drugs he testified as follows:

Q: Were you aware of allegations in that case [Moeller] by Mr. Moeller's attorneys that compounding drugs was somehow a fringe occupation or an unusual practice in the practice of either pharmacy or medicine:

A: I have heard that allegation, and at least with regard to anesthetic drugs and in my practice, that is just not true.

Q: Insofar as you use compounded drugs in the practice of anesthesia, does the standard of care require you or any other anesthesiologists to trace the drug back to its origins of manufacture before you use it?

A: No. I rely on the pharmacy to properly prepare the medication and label it before they send it to the hospital.

Q: And the standard of care in the practice of anesthesiology permits you to rely on a licensed pharmacist in good standing to provide you with an effective, potent and sterile drug?

A: Yes.

Q: And doctor, does the licensure of a drug supplier, whether they're either a manufacturer or merely a wholesaler, does the FDA licensure of that manufacturer, supplier provide you with sufficient assurance as an anesthesiologist that the drug that you are using on a patient is pure, effective and sterile?

A: Yes.

Exhibit 26R p. 16, lines 23-24-p.18, line 3. Dr. Dershwitz also opined that ERM A.12 (B) if performed as written would provide a painless and humane death. Exhibit 26R, p. 19, line 18. Like Dr. Heath's testimony, this Court does not find Dr. Sellers' testimony to be particularly reliable, relevant or useful. Rather, this Court finds Dr. Dershwitz's, who is an anesthesiologist and has a degree in pharmacology, to be more credible and believable.

> We give deference to circuit courts in determining the credibility of a witness. *Hubbard v. City of Pierre*, 2010 S.D. 55, ¶ 26, 784 N.W.2d 499, 511 (reiterating that "the credibility of the witnesses, the import to be accorded their testimony, and the weight of the evidence must be determined by the trial court, and we give due regard to the trial court's opportunity to observe the witnesses and examine the evidence.").

Nemec v. Goeman, 2012 S.D. 14, ¶24, 810 N.W.2d 443, 449. Petitioner has not submitted any credible evidence that the compounded drug is not reliably pure and potent and poses a substantial risk of severe pain to the inmate. In fact, post-compounding testing of pentobarbital used in the Robert and Moeller executions proved that it was, in fact, compounded into a sterile, USP-compliant injectable solution. Exhibit 11R, at ¶V(G); Exhibit 4R, ¶¶9, 11, 12; Exhibit 3R, Weber/Moeller Affidavit at ¶6; Exhibit 5R, Deponent #1 Affidavit at ¶1. Therefore, Rhines'

argument that the compounding of pentobarbital results in a drug that is not reliably pure and potent must fail.

iv. Witness #1
Compounding Pharmacist

Rhines further argues that the pharmacist hired to compound the pentobarbital is incompetent. Again, the pharmacist employed for the Robert and Moeller executions meets and surpasses the minimum qualification thresholds set by *Baze*. Witness #1 has a bachelor's degree in pharmaceutical science. His education program required five years of undergraduate/graduate education. Exhibit G, p. 25-28. He also obtains approximately 20 hours a year in continuing education. Exhibit G, p. 25-28. He has specialized training in sterile compounding. Exhibit G, p. 86. He is licensed and registered with a Board of Pharmacy. His pharmacy license and registration are current. Exhibit G, p. 21-22. He has never been investigated for improper compounding practices. Exhibit G, p. 38, 57. He has many years of experience as a working compounding pharmacist. Exhibit G, p. 22, 28. Witness #1 testified that compounded drugs do not require FDA approval like commercial drugs. Exhibit G, p. 41, 155. His pharmacy complies with USP guidelines for sterile compounding. Exhibit G, p. 86, 133-135, 152.

Witness #1 is qualified under ERM A.12(B) and the *Baze* decision. Rhines' argument that the compounded drug is not reliably pure and potent and that the pharmacist is incompetent to compound pentobarbital are without merit.

Issue Two

Whether Petitioner's challenge to the lethal injection protocol adopted and implemented by the State of South Dakota as set forth in detail in Petitioner's Habeas Petition Grounds 8, 11 and 12, violates Article VI, §23 of the South Dakota Constitution prohibition against Cruel and Unusual Punishment?

Rhines' final argument is that the South Dakota State Constitution, Article VI, §23 provides greater protection than the United States Constitution. He further argues that the South Dakota Supreme Court has not addressed the issue of the manner of carrying out the death penalty. The South Dakota Constitution provides in Article VI, §23:

> Excessive bail shall not be required, excessive fines imposed, nor cruel punishments inflicted.

While Rhines' argument focuses on the manner of carrying out the death penalty instead of whether the death penalty is unconstitutional, it is clear that the South Dakota Supreme Court has addressed the issue of the death penalty:

> The South Dakota Constitution employs slightly different language in limiting the government's power to impose criminal penalties. Article VI, § 23, of the South Dakota Constitution states: "Excessive bail shall not be required, excessive fines imposed, nor cruel punishments inflicted." (Emphasis supplied.) Moeller argues that South Dakota's

constitutional prohibition on "cruel punishments" is a greater restriction on government power than its federal counterpart prohibiting "cruel and unusual punishments." He contends that the death penalty is invariably a "cruel punishment" in violation of this state's constitutional provision.

We note that a state constitution may be interpreted to provide an individual with greater protection than the federal constitution. *State v. Opperman*, 247 N.W.2d 673, 674 (S.D.1976). Additionally, "capital punishment is a matter of particular state interest or local concern and does not require a uniform national policy." *State v. Ramseur*, 106 N.J. 123, 524 A.2d 188, 209 (1987). See also James R. Acker & Elizabeth R. Walsh, Challenging the Death Penalty Under State Constitutions, 42 Vanderbilt LRev 1299 (1989).

Cognizant of this Court's independent authority to invalidate capital punishment as a matter of state law, we begin our analysis by focusing on our own state's legal and historical precedent. Importantly, the very same constitutional document that prohibits the infliction of cruel punishment contains provisions implicitly recognizing the appropriateness of the death penalty. S.D. Const.Art. VI, § 8, states in part: "All persons shall be bailable by sufficient sureties, except for capital offenses when proof is evident or presumption great." (Emphasis supplied.) Article VI, § 2, provides in pertinent part: "No person shall be deprived of life ... without due process of law."

In addition to constitutional recognition, capital punishment has received legislative approval. The death penalty has been in effect for most of this state's history. Capital punishment existed from statehood until it was abolished in 1915. *Opinion of the Judges*, 83 S.D. 477, 479, 161 N.W.2d 706, 708 (1968). It was reinstated in 1939 and continued until 1972, when the United States Supreme Court effectively invalidated the then-existing capital sentencing scheme. Reed C. Richards & Stephen C. Hoffman, Death Among the Shifting Standards: Capital Punishment After Furman, 26 SDLRev 243 (Spring 1981). The legislature reenacted the death penalty in 1979, and it has remained in effect to the present. Richards & Hoffman, supra, at 243; 1979 S.D.Sess.L. ch. 160; 1981 S.D.Sess.L. ch. 186. Eleven individuals have been executed in South Dakota. Richards & Hoffman, supra, at 243.

State v. Moeller, 1996 S.D. 60, ¶¶ 97- 101, 548 N.W.2d 465, 487. The South Dakota Supreme Court adopted the test set forth in *Gregg v. Georgia*, 428 U.S. 153, 96 S.Ct. 2909 (1976):

Historical and legislative acceptance of the death penalty is significant, but not dispositive. See *State v. Black*, 815 S.W.2d 166, 188 (Tenn.1991). Constitutional analysis is dynamic and evolving; it cannot rest solely on historical underpinnings. We therefore adopt a three-part analytical framework derived from the United States Supreme Court's plurality decision in Gregg. To survive constitutional scrutiny, the death penalty: (1) must comport with contemporary standards of decency; (2) must not be excessive in light of the crime committed; and (3) must serve a legitimate penological objective. *Gregg*, 428 U.S. at 173–83, 96 S.Ct. at 2924–30, 49 L.Ed.2d at 874–80.

Moeller, p. 487-488, ¶102. The South Dakota Supreme Court went on to hold that South Dakota's capital punishment was constitutional and met the three part test set forth in *Gregg*.

> We conclude that capital punishment meets all three of these requirements. To begin with, the death penalty comports with South Dakotans' contemporary standards of decency. Because the legislative branch is most representative of the views of the people, legislative enactments are one of the most accurate indicators of societal mores. *Gregg*, 428 U.S. at 179–81, 96 S.Ct. at 2928–29, 49 L.Ed.2d at 878–79; *Commonwealth v. Zettlemoyer*, 500 Pa. 16, 454 A.2d 937, 968 (1982), cert. denied, 461 U.S. 970, 103 S.Ct. 2444, 77 L.Ed.2d 1327 (1983); Black, 815 S.W.2d at 189; *State v. Campbell*, 103 Wash.2d 1, 691 P.2d 929, 948 (1984), cert. denied, 471 U.S. 1094, 105 S.Ct. 2169, 85 L.Ed.2d 526 (1985). The South Dakota Legislature reenacted the death penalty in 1979, and has made occasional amendments to the statutory scheme since that time. 1979 S.D.Sess.L. ch. 160; 1981 S.D.Sess.L. ch. 186; 1989 S.D.Sess.L. ch. 206; 1992 S.D.Sess.L. ch. 173; 1994 S.D.Sess.L. ch. 178; 1995 S.D.Sess.L. ch. 132. These statutes have remained undisturbed by the electorate, despite the power of the people to vote death penalty proponents out of office or to reject legislative enactments through a referendum election. This public acquiescence is strong evidence that capital punishment reflects the will of the people of South Dakota.

As noted in *Baze*, States have long explored using lethal injection as a manner of assuring humane method of execution. Baze, 553 U.S. 35, 42, 128 S.Ct. 1526-1527. At the time *Baze* was decided in 2008, 36 states had adopted lethal injection as the exclusive or primary means of implementing the death penalty. *Id.* It is also the method used by the Federal Government. *Id.* See 18 USC § 3591 *et seq*. (2000 ed. and Supp.V).

In South Dakota, the Supreme Court has found the death penalty to be Constitutional under both the United States Constitution and the South Dakota Constitution. In this Court's opinion, lethal injection is the most humane manner of implementing the death penalty and therefore, it is constitutional under the South Dakota Constitution.

III. CONCLUSION

For the reasons set forth above, the Court hereby denies Petitioner's Writ of Habeas in its entirety.

ORDER

ACCORDINGLY, it is hereby ORDERED that Petitioner's Writ of Habeas Corpus is denied and Respondent shall submit Findings of Fact and Conclusions of Law in accordance with this decision.

Dated this 27 day of February, 2013 at Rapid City, Pennington County, South Dakota.

BY THE COURT

Honorable Thomas L. Trimble
Circuit Judge, Seventh Judicial Circuit

ATTEST:
Ranae Truman, Clerk of Courts
By: _____
Deputy Clerk

(SEAL)

Pennington County, SD
FILED
IN CIRCUIT COURT
FEB 27 2013
Ranae Truman, Clerk of Courts
By _____ Deputy

SUPREME COURT
STATE OF SOUTH DAKOTA
FILED

JUL 17 2013

Clerk

IN THE SUPREME COURT

OF THE

STATE OF SOUTH DAKOTA

* * * *

CHARLES RUSSELL RHINES, Petitioner, vs. DOUGLAS WEBER, Warden, South Dakota State Penitentiary, Respondent.	ORDER DENYING MOTION FOR CERTIFICATE OF PROBABLE CAUSE #26673

Petitioner having served and filed a motion for a certificate of probable cause to appeal from a final order entered by the trial court in the above-entitled habeas corpus proceeding on April 29, 2013, and respondent having served and filed a response thereto, and the Court having considered the motion and response and having determined that probable cause that an appealable issue exists has not been demonstrated, now, therefore, it is

ORDERED that the motion for a certificate of probable cause be and it is hereby denied.

DATED at Pierre, South Dakota, this 17th day of July, 2013.

BY THE COURT:

David Gilbertson, Chief Justice

ATTEST:

Clerk of the Supreme Court
(SEAL)

(Justices John K. Konenkamp and Lori S. Wilbur disqualified.)

PARTICIPATING: Chief Justice David Gilbertson and Justices Steven L. Zinter, Glen A. Severson, Circuit Court Judge Scott P. Myren and Retired Justice Robert A. Miller.

EXHIBIT
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH DAKOTA
WESTERN DIVISION

CHARLES RUSSELL RHINES,

Petitioner,

vs.

DARIN YOUNG, Warden,
South Dakota State Penitentiary,

Respondent.

CIV 00-5020-KES

PETITIONER'S RESPONSE TO STATE'S MOTION FOR SUMMARY JUDGMENT

I. RESPONDENT'S MOTION FOR SUMMARY JUDGMENT DOES NOT CONFORM WITH LOCAL RULE 56.1A AND SHOULD BE DENIED.

Respondent has filed a motion for summary judgment pursuant to Federal Rule of Civil Procedure 56. Under Local Rule 56.1A, Respondent was required to submit with its motion "a separate, short, and concise statement of the material facts as to which the moving party contends there is no genuine issue to be tried. Each material fact will be presented in a separate numbered statement with an appropriate citation to the record in the case." Respondent has filed no such statement of allegedly undisputed material facts.

"The purpose of local rule like Local Rule 56.1A 'is to distill to a manageable volume the matters that must be reviewed by a court undertaking to decide whether a genuine issue of fact exists for trial." *Sancom, Inc. v. Qwest Communications Corp.*, 2010 WL 299477, *1 (D.S.D. 2010) (unpublished). Thus,



II. "Method of Execution Challenge"

Respondent devotes some fifty pages of his Brief in Support of Respondent's Motion for Summary Judgment to an issue which is not before the Court. (Doc. No. 215, pp. 111-161). As Respondent notes in the "Procedural History" section of Doc. No. 215, after being denied relief on the grounds raised in his initial state habeas corpus petition, Mr. Rhines "filed his petition herein in which he alleged new unexhausted grounds for *habeas corpus* relief in addition to all of the claims he had exhausted in the state courts." (*Id.* at 1-2. *See* Doc. No. 73 (First Amended Petition)). After extended briefing by the parties, the Court entered its Order (Doc. No. 116) denying without prejudice Respondents' motion to dismiss (Doc. No. 77); finding that Grounds Two(A), Three, Four and Ten of the First Amended Petition had been exhausted and would be considered on their merits; finding that Grounds Two(B), Six(E), Nine(B), (H), (I) and (J), Twelve and Thirteen were unexhausted; and staying the petition pending exhausting state court remedies of those claims. (Doc. No. 116 at 9-10). That Order was appealed to the United States Court of Appeals for the Eighth Circuit, which reversed and remanded. *Rhines v. Weber*, 346 F.3d 799 (8th Cir. 2003). The United States Supreme Court granted certiorari "to resolve a split in the Circuits regarding the

District Court's 'stay-and-abeyance' procedure," *Rhines v. Weber*, 544 U.S. 269, 273 (2005), vacated the Eighth Circuit's judgment and remanded the case to that court to consider whether this Court's grant of a stay constituted an abuse of discretion. *Id.* at 279. The Eighth Circuit remanded the case to this Court to determine whether there was good cause for failure to exhaust the claims in state court, whether any unexhausted claims were plainly meritless and whether Mr. Rhines had engaged in "abusive litigation tactics or intentional delay." *Rhines v. Weber*, 409 F.3d 982 (8th Cir. 2005).

After further briefing and argument by the parties, this Court entered its Order Granting Motion for Stay and Abeyance (Doc. No. 150), finding that Mr. Rhines had good cause for failing to exhaust the claims, that the claims – with the exception of claim Thirteen, which Mr. Rhines subsequently withdrew and dismissed (*see* Doc. No. 152) – were not plainly meritless, and that Mr. Rhines had not engaged in intentionally dilatory litigation tactics. Therefore, the Court stayed the petition for habeas corpus pending exhaustion of Grounds Two(B), Six(E), Nine(B), (H), (I), (J), and Twelve in state court. (Doc. No. 150 at 19).

None of the claims in the original or the First Amended Petition for Writ of Habeas Corpus, exhausted or unexhausted, concerned the manner of execution.

Therefore the issue of manner of execution, which was included in the latest litigation in the state court, and which was discussed at such length in Respondent's brief, is not before this Court, and this Court cannot issue any sort of judgment concerning that issue.

III. Ground One: Admission of Petitioner's Confession

A. Insufficiency of *Miranda* Warnings.

In Ground One Mr. Rhines contends that his multiple confessions were admitted in violation of the Fifth and Fourteenth Amendments. Specifically Mr. Rhines alleges that law enforcement failed to give adequate warnings pursuant to *Miranda v. Arizona*, 384 U.S. 436 (1966) and its progeny. *Miranda* requires that before a person in custody may be subjected to interrogation,

> [h]e must be warned prior to any questioning that he has the right to remain silent, that anything he says can be used against him in a court of law, that he has the right to the presence of an attorney, and that if he cannot afford an attorney one will be appointed for him prior to any questioning if he so desires. Opportunity to exercise these rights must be afforded to him throughout the interrogation.

384 U.S. at 479. After such warning have been given, the individual may waive these rights. *Id.* "But unless and until such warnings and waiver are demonstrated

AFFIDAVIT OF MARK DERSHWITZ, M.D., Ph.D.

COMMONWEALTH OF MASSACHUSETTS)
) ss:
COUNTY OF WORCESTER)

I, Dr. Mark Dershwitz, of lawful age, being first duly sworn upon oath, state:

1. I have been asked to prepare this expert report by attorneys for the defense in the case of Moeller v Weber. I have previously submitted affidavits in this case on 31 May 2011 and 12 September 2011.
2. I am a medical doctor with a Ph. D. in Pharmacology. A true and accurate copy of my curriculum vitae is attached as Exhibit A. I am licensed to practice medicine in the states of Massachusetts and Maine. I am currently an anesthesiologist at the University of Massachusetts and I am certified by the American Board of Anesthesiology. I am currently Professor of Anesthesiology and Biochemistry & Molecular Pharmacology at the University of Massachusetts.
3. I have done extensive research and written numerous review articles and research papers on the use of anesthetics and I regularly practice medicine in that capacity. My research includes the study of pharmacodynamics and the pharmacokinetics of drugs. Pharmacokinetics is the study of the time course of a drug, while pharmacodynamics refers to the effects of a drug. Prior to my current appointment at the University of Massachusetts, I was an Instructor,

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Assistant Professor and Associate Professor at Harvard Medical School.

4. I have testified as an expert witness concerning the pharmacokinetics and the pharmacodynamics of anesthetic drugs and other medications. I have testified in court as an expert witness on twenty-four occasions. I have given fifty-three depositions as an expert witness. The list of cases in which I have testified is attached as Exhibit B.

5. I have reviewed the protocols for lethal injection used in the states of Arkansas, Alabama, Arizona, California, Delaware, Florida, Georgia, Kentucky, Maryland, Missouri, Montana, North Carolina, Ohio, Oklahoma, South Carolina, South Dakota, Texas Virginia, and Washington and by the federal government. Most of the states (and the federal government) employ similar three-drug protocols for carrying out lethal injection. While the protocols and the jurisdictions differ in terms of the doses and identities of the three medications used, each of these protocols, when implemented as written, will render an inmate unconscious quickly and cause the inmate's rapid and painless death.

6. I have reviewed a document entitled, "ERM A.12(B) Capital Punishment Final Days Procedures," dated 13 October 2011. The document contains instructions for using *either* thiopental or pentobarbital as the first drug, or as the only drug, in the protocol. I have been informed by attorneys for the defense in this case that the State of South Dakota intends to use pentobarbital as the first drug, or as the only drug, in the lethal injection protocol. Exhibit C is a copy of the analysis of the lot of pentobarbital vials that the State of South Dakota intends to use for lethal injection. This analysis demonstrates that the pentobarbital meets the

standards set forth by the United States Pharmacopeial Convention.

7. The document, "BRM A.12(B)" states that medications will be administered as follows in the three-drug protocol:

a. Two intravenous catheters will be inserted.

b. Syringes 1 and 2, each containing 2.5 grams of pentobarbital in a volume of 50 mL, for a total dose of 5 grams, will be injected.

c. Syringe #3 containing 25 mL of saline solution will be injected to flush the intravenous line.

d. The warden will confirm that the inmate is unconscious.

e. Syringe 4 containing 100 mg of pancuronium bromide in a volume of 50 mL will be injected.

f. Syringe #5 containing 25 mL of saline solution will be injected to flush the intravenous line.

g. Syringes 6 and 7, each containing 120 mEq of potassium chloride in a volume of 60 mL, for a total dose of 240 mEq, will be injected.

8. It is expected that a 5-gram dose of pentobarbital will cause the inmate's electro-encephalogram (EEG or recording of brain waves) to become flat. This is the deepest level of anesthesia that can be measured with the brain monitors available today, and is much deeper than barbiturate coma that is in turn deeper than surgical anesthesia.

9. Pentobarbital is commonly used to produce barbiturate coma in the attempt to decrease the degree of brain damage following head trauma, stroke, and other causes of brain damage. It is also used to prevent brain damage during surgical

procedures in which there will be the planned and deliberate interruption of blood flow to the brain. A typical dosing regimen for the institution and maintenance of barbiturate coma is as follows:

a. Pentobarbital, 10 mg/kg, (or 800 mg in an average 80-kg adult) is given by intravenous infusion over 30 minutes.

b. A continuous infusion of pentobarbital at a rate of 5 mg/kg/hr (or 400 mg/hr in an average 80-kg adult) is given for 3 hr.

c. The patient's EEG is monitored for the presence of "burst suppression." The appearance of "burst suppression" on the EEG means that there are *intermittent* periods of electrical inactivity (i.e., flat-line).

d. The pentobarbital infusion rate is then adjusted between 1 – 5 mg/kg/hr (or 80 – 400 mg/hr in an average 80-kg adult) to maintain the presence of burst suppression on the EEG.

e. Because this dose of pentobarbital results in apnea, i.e., the cessation of breathing, the patient is mechanically ventilated.

10. Using the above regimen in an 80-kg adult, it would take between 11 – 41 hr to achieve the administration of 5,000 mg of pentobarbital. There are two reasons that pentobarbital is not given more rapidly or at a higher dose to induce barbiturate coma. First, the dose regimen described in Paragraph 8 is adequate to induce and maintain burst suppression on the EEG. Second, more rapid administration of pentobarbital causes severe and dangerous decreases in blood pressure that might be fatal to the patient.

11. The use of pentobarbital in barbiturate coma has been part of medical practice

from the mid-1970's until the present day. It is neither a novel nor an archaic medical therapy. I have attached two journal articles, one from 1979 and the other from 2010, as Exhibits D and E, respectively, to demonstrate this point.

12. The end-point of burst suppression on the EEG is a deeper level of general anesthesia than is needed for any surgical procedure. Therefore, since the protocol for lethal injection described in Paragraph 7 describes a dose of pentobarbital far in excess of that used to induce and maintain barbiturate coma, and since this is a depth of anesthesia far greater than that needed for any surgical procedure, once 5,000 mg of pentobarbital have been administered intravenously to an inmate, there is, to a reasonable degree of medical certainty, an exceedingly remote chance that the inmate could experience the effects of the subsequently administered pancuronium bromide or potassium chloride.

13. A dose of 5,000 mg of pentobarbital will cause virtually all persons to stop breathing. In addition, a dose of 5,000 mg of pentobarbital will cause the blood pressure to decrease to such a degree that perfusion of blood to organs will cease or decline such that it is inadequate to sustain life. Thus, although the subsequent administration of pancuronium bromide, a paralytic agent, would have the effect of paralyzing the person and preventing him or her from being able to breathe, virtually every person given 5,000 mg of pentobarbital will have stopped breathing prior to the administration of pancuronium bromide. Thus, even in the absence of the administration of pancuronium bromide and potassium chloride, the administration of 5,000 mg of pentobarbital by itself would cause death in almost everyone.

14. Pentobarbital is the most common agent used in the euthanasia of pet cats and dogs by veterinarians. The usual dose is 40 mg/kg. The use of a dose of 5,000 mg in an 80-kg inmate as part of the lethal injection protocol is greater than a 50% increase as compared to the dose used in animal euthanasia.

15. Therefore, it is my opinion to a reasonable degree of medical certainty that there is an exceedingly remote chance that a condemned inmate to whom 5,000 mg of pentobarbital is properly administered pursuant to the lethal injection protocol of the State of South Dakota would experience any pain and suffering associated with the administration of lethal doses of pancuronium bromide and potassium chloride.

16. An inmate sentenced to death in South Dakota may under some circumstances elect the two-drug protocol. The two-drug protocol is identical to the procedure described in Paragraph 7 except that the syringes of potassium chloride are not injected. It is my opinion to a reasonable degree of medical certainty that there is an exceedingly remote chance that a condemned inmate to whom 5,000 mg of pentobarbital is properly administered pursuant to the lethal injection protocol of the State of South Dakota would experience any pain and suffering associated with the administration of a lethal dose of pancuronium bromide.

17. An inmate sentenced to death in South Dakota may under some circumstances elect the one-drug protocol. In this protocol, the inmate is administered a 5-gram dose of pentobarbital alone. It is my opinion to a reasonable degree of medical certainty that there is an exceedingly remote chance that a condemned inmate to whom 5,000 mg of pentobarbital is properly administered pursuant to the lethal

injection protocol of the State of South Dakota would experience any pain and suffering.

18. I am being compensated at the rate of $450 per hour.

FURTHER AFFIANT SAIETH NOT.

Dated this 9th day of February, 2012.

Mark Dershwitz, M.D., Ph.D.

Subscribed and sworn to before me this 9th day of February, 2012.

Notary Public

LISA L. NICHOLSON
Notary Public
Commonwealth of Massachusetts
My Commission Expires
February 6, 2015

Mark Heath, M.D.

STATE OF SOUTH DAKOTA
COUNTY OF PENNINGTON
IN CIRCUIT COURT
SEVENTH JUDICIAL CIRCUIT
CIV. 02-924

CHARLES RUSSELL RHINES,

Petitioner,

vs.

DOUGLAS WEBER, Warden, South Dakota State Penitentiary,

Respondent.

Videotaped Deposition Transcript of MARK HEATH, M.D., in the above-entitled matter, as taken by and before, DEBRA GOODFRIEND, a Certified Shorthand Reporter and Notary Public for the State of New York, held at the offices of Federal Defenders of New York, 52 Duane Street, New York, New York, on December 1, 2012, commencing at 9:45 a.m.

EXHIBIT tabbies 8

Mark Heath, M.D.

APPEARANCES:

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ALSO PRESENT:
Marcelo Rivera, Videographer

Mark Heath, M.D.

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EXHIBITS

(No Exhibits Marked By Reporter.)

Mark Heath, M.D.

THE VIDEOGRAPHER: This is DVD No. 1 of the video deposition of Dr. Mark Heath in the matter, Rhines vs. Weber. This deposition is being held at 52 Duane Street, New York, New York on December 1st, 2012 at approximately 9:53 a.m.

My name is Marcelo Rivera from Alderson Court Reporter.

Will the present counsel please introduce themselves, for the record.

MR. FULTON: Neil Fulton, from the Federal Public Defender's office, for the plaintiff.

MR. SWEDLUND: Paul Swedlund, the South Dakota Attorney Generals Office, for the defendant.

THE VIDEOGRAPHER: Will the court reporter please swear in the witness.

MARK HEATH, M.D., having been first duly sworn by a Notary Public from the State of New York was examined and testified as follows:

DIRECT EXAMINATION BY MR. FULTON:

Q. Can you start out by telling us your name?

A. My name is Mark Heath.

Q. And Dr. Heath, I'm going to refer to you

Mark Heath, M.D.

as Dr. Heath today, and not be so informal as to call you Mark. Can you tell us how you're employed?

A. I'm an anesthesiologist. I work at Columbia University Medical Center in New York City.

Q. I want to go back through your education just a little bit. Perhaps the easiest way to do is that you have in front of you something marked Exhibit 3. What is that document?

A. It's my curriculum vitae.

Q. Can you tell us the highlights of your professional education. We don't need to go all the way back to high school, but where you did your medical education and residency?

A. I did my medical education at University of North Carolina in Chapel Hill. After that I did a one-year internship in internal medicine in Washington D.C., and then I did an internship in anesthesiology at Columbia University Medical Center in New York City. I then did a fellowship that was a mixture of research and specializing in cardiac anesthesia for about a year-and-a-half, again at Columbia. And then I joined the faculty of Columbia University as an anesthesiologist and a staff member of the hospital.

Q. When was that, that you joined the

Mark Heath, M.D.

A. Correct.

Q. So for one way to think about it, you could have a contaminant that made the process unintendedly painful or improper on the way to death or something that happens after an interrupted execution?

A. Right.

MR. SWEDLUND: Can I ask a question. Were you talking about introduction of a contaminant at what stage were you talking about?

Q. Doctor, we're not talking about you being the expert on how and when the drugs are compounded, correct?

A. Correct. I think that's correct. That's up to you, but yes.

Q. But you have in your practice administered compounded drugs?

A. I've administered drugs where I've mixed the drug myself and I've used drugs that have been compounded by the pharmacy at the hospital.

Q. Okay. And to sort of address Paul's question, I mean, you have some understanding of how the compounding process works?

A. Yes.

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Q. Tell us a little bit about points in the process where based on your experience you see the potential for contaminants potentially to be introduced?

A. Well, it can happen anywhere from the assembly of the ingredients for the actual chemical, the turning or synthesis that those ingredients into the chemical that is going to be the drug, the shipping, handling, storage of that chemical, then the preparation of that chemical, that chemical which is going to be the drug, into the actual package drug form, and then the transport of that to the place of storage or place of use. Problems can happen during storage, after it's removed from storage. Problems can happen during the drawing up of the drug into a syringe at its point of use. Basically anywhere in the full chain from the precursor molecules involved in the synthesis of the chemical throughout the process of turning that chemical into an actual drug and the handling of the drug in preparation for administration.

Q. To be fair in drawing the boundary about your opinion, you are not identifying a specific point in South Dakota's protocol where you're saying there

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will be a contaminant introduced, you're just saying it's a potential that exists?

A. Yes.

Q. And it's a potential that can make the execution less humane?

A. Yes.

Q. Let's talk, specifically, if we can, about the drug pentobarbital. Is that a drug that you're familiar with?

A. Yes.

Q. Tell us a little bit about what it is?

A. It's a drug in a class called barbiturates or barbiturates. The spelling is the same but people pronounce it differently. Barbiturates are drugs that when they reach the brain cause depression of the brain, and if they're given in sufficient dose will cause drowsiness and then unconsciousness.

Q. Is it a drug that you administered in your practice?

A. I have, yes.

Q. What is it typically used for in anesthesiology?

A. It's not used very often at all in

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anesthesiology. The main use would be in a clinical situation where there was a need to greatly reduce the activity of the brain because either the brain has received trauma or is going to be subjected to injury as a result of a surgical procedure.

Q. In terms of its operation, can you compare the speed, the nature in which it operates with other barbiturates a little bit?

A. Yes. Barbiturates are typically divided into classes, depending on how rapidly they exert their action and for how long they exert their action. So the classes, there are different ways that people do it, but typically they talk about ultra short, ultra fast-acting barbiturates, and then short-acting barbiturates, and medium-acting barbiturates and long-acting barbiturates. And pentobarbital is typically put into the short or medium-acting categories depending on which author is referring to it.

Q. And being a short or medium-acting barbiturate, what does that mean in terms that a layperson can understand in terms of its effect on the person that's being anesthetized?

A. I'll just start by comparing ultra-short

and ultra-fast acting barbiturates which will enter the brain very quickly in a matter of tenths of seconds, and will also leave the brain very quickly and be taken up by other parts of the body, the fat areas of the body. By contrast -- and those drugs would be the class of drug would be thiopental, for example, and another would be a drug called methohexital. By contrast, pentobarbital is slower to take effect and lasts for longer. So instead of wearing off in a matter of a couple of minutes, pentobarbital would typically last for hours.

Q. You have reviewed the protocol and have an understanding at least a paper level of how the State of South Dakota intends to use pentobarbital as a lethal injection drug, yes?

A. Yes.

Q. And tell us a little bit based on your training and experience how that drug would operate in an execution carried forward with no outside problems, it goes according to plan, so to speak?

A. Just to be clear, I've never seen it used in an execution, so I'm a little bit speculating. But I have read about executions where it's been used and I can speculate based on my knowledge about

barbiturates and pentobarbital and human physiology and drug interactions in general. If the intended dose of pentobarbital were to be successfully delivered into the circulation of a person and carried to their brain in this dose it would cause complete depression of all the brain activity such that there would be no electrical activity in the brain whatsoever. The electrical activity of the brain sustains many important bodily functions, but in particular it sustained respiration, the rhythmic breathing that we do all the time and when pentobarbital or any barbiturate would stop all activity in the brain, it without stop what we call the respiratory drive. It would stop breathing from occurring. When an animal or person doesn't breathe then after a period of several minutes the brain starts to sustain injury from lack of oxygen and then it starts to sustain permanent death of the neurons, which are the cells that carry information to the brain. At some point after a number of minutes the neurons in the brain will be irreversibly damaged and/or dead, the condition that we call brain death, and that is legally a type of death, a form of death. It's possible that the heart might be still sustaining

activity, but at that point the person would be legally dead.

Q. In our discussion of compounding you mentioned the potential for a drug to be less efficacious than it should. Now, based on your review of the protocol if it -- how would the administration of a less than appropriately efficacious amount of pentobarbital manifest to result in an inhumane execution?

A. My concern would be that the prisoner would be administered a dose that would impair respiration or temporarily prevent respiration, but it does sub-lethal and did not effectively kill the person. And in that instance, which happens in barbiturate overdose, when people try to commit suicide or accidentally ingest it or ingestion barbiturates for illicit recreational purposes, the person can spend a period of time breathing inadequately or not at all, but it is not such a time that they actually die from that. When the drug wears off the person can be left with a brain injury or brain damage or also injury to other organs in the body.

Q. So you would end up in a situation where

a person had received too little or not effective enough pentobarbital to actually complete the process of killing them, but too much to simply anesthetize them so they can be simply brought back of the anesthetized state?

A. I'm sorry, can you say that again. Not enough --

Q. You've given too much to them to just anesthetize them and not enough to kill them?

A. You've given them an amount that would -- be anesthetic, they probably would be unconscious and not feel anything. They would be not breathing very much, very low amount of respiration. They would be in that state for a period of time until the drug wore off. And when the drug wore off they would be left with brain injury.

Q. If I can have you look at page 4 of your September 13th, 2012 declaration. It's Exhibit 6. You mention in paragraph 60, that as a medical practitioner, you would be, quote, highly reluctant, close quote, to use an anesthetic agent that would be handled and compounded in the manner described and complicated by the SD DOC.

When you make that statement I assume

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here today, do you hold those to a reasonable degree of medical certainty?

A. Yes, I do.

Q. And you've had an opportunity to review before today Exhibits 4, 5 and 6 which are your declarations in the Moeller litigation?

A. Yes.

Q. The opinions expressed in there are also to a reasonable degree of medical certainty?

A. The medical opinions are, yes.

Q. Although we've not gone through them all today, based on your review you still hold the opinions expressed in Exhibits 4, 5 and 6?

A. Yeah. Except where I provided more information and changed it as to the more recent affidavits.

MR. FULTON: Doctor, those are the questions I have. Mr. Swedlund is going to have some questions he's going to ask you, too.

MR. SWEDLUND: Could we take a break.

THE VIDEOGRAPHER: The time is 11:19 a.m. and we're going off the record.

(There was a break in the proceedings.)

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The time is 11:37a.m. and we're back on the record.

EXAMINATION BY MR. SWEDLUND:

Q. Doctor, I wanted to cover something with you here that I wasn't entirely clear on. You are opposed to the death penalty; is that correct?

A. The way it's being practiced in the United States now, yes.

Q. Well, your opposition goes beyond just how it's practiced, you oppose the very idea of the death penalty?

A. You know, I don't really think about the extracted idea of the death penalty, just what I see from participating in this litigation and by, when I read about many of the cases I think that society would be better off if we did not do this.

Q. So clarify then for me please, doctor. Are you saying that you oppose it only as it is practiced or you have a deeper moral opposition to the death penalty?

A. Opposition is the wrong word. I have a lot of concerns about it because I feel that it's hard to know with certainty in all cases that it's really a guilty person on death row.

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Q. So I'm going to look at your testimony in a case that you gave, the Evans versus Star case. Do you recall testifying in that case?

A. What state is that?

Q. That's in Maryland.

A. Okay.

Q. You were asked; do you disapprove of executions in general. And your answer was; yes.

Question: So all manner of executions that have taken place legally in the United States you disapprove of?

And you say: The only qualification is that I think there's theoretical exigent circumstances where I think it might be necessary to execute somebody because the alternative would be worse. But putting that theoretical situation aside, yes, it's correct that I at the present time do not approve of elected executions of people.

Is that still your position today?

A. Yes.

Q. Or have you changed it?

A. I'm sure it's, it's a fluid thing but I agree with those statements.

Q. Again, in the Rivera case do you recall

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testifying in that case?

A. You have to tell me what state it was.

Q. Ohio.

A. I don't specifically recall, but by that name, but I'll accept that.

Q. And you were asked: As it currently exists you are against the death penalty in whatever form it exists at this time.

Answer: I'm opposed to the carrying out of the death penalty.

Question: Then that would be the same no matter how painless it would be?

Answer: That's correct. Even if it were done in a completely painless way I'm very uncomfortable with killing a person in any way.

That was a statement you made in Rivera. Do you remember that now?

A. I don't remember it, but I agree with it.

Q. You agree with it?

A. Yes.

Q. So your misgivings about the death penalty go beyond merely how it is performed you have a moral objection to it, as well?

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A. I'm not sure moral is the right word for it. I don't think that as it's currently practiced in the U.S. or probably anywhere else in the world, although I don't really know about its practice elsewhere, I think it's a mistake.

Q. And you were asked: You never found an acceptable lethal injection protocol for human beings? And your answer: That's correct.

Is that still true today?

A. Yes, South Dakota is better than the great majority of other jurisdictions, but it still has flaws and they're correctable and they should be corrected.

Q. But you have to this day you have never found a lethal injection protocol that you considered acceptable?

A. Not for humans. For veterinary euthanasia, yes, but for lethal injection as has been carried out for legal proceedings, no.

Q. Whether your objection to the death penalty is moral or merely to the mechanics of it, do your opinions about the death penalty in any way color your objectivity about your review of protocols?

A. I do my best to go beyond any bias that

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I might have but the definition of subconscious bias is one can't know when one has one. So I try to eliminate conscious bias as much as possible, but I can't speak to subconscious bias, because anybody who claims they can doesn't understand what that is.

Q. So some bias may enter into your evaluation of a protocol or how it's used?

A. Yes, subconscious bias certainly could be there.

Q. Doctor, if I understand your position on this as well from your previous testimony, it's your belief that a surgical standard of care applies to a lethal injection proceeding whether it's one drug or three drugs?

A. I wouldn't use the word surgical standard of care. Clinical standard of care should apply if one wants to have the same reliability as a clinical procedure.

Q. Let me ask it a different way. Do you believe that the persons who perform a lethal injection should be held in the same standards as persons who administer anesthesia in the operating room?

A. Not necessarily. But for the key parts

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of it in terms of assessing -- of preparing the drugs, administering the drugs, setting up the equipment, monitoring the effects of the drugs and being able to detect and intervene if a problem is occurring, then I think they should be held to that standard.

Q. Because you said in some of your answers that, for example, the pusher and I don't mean to use those terms to denigrate what he does and I use them because they bring clarity to the role that the person plays, but in reference to the pusher you stated that this person wouldn't have qualifications to be hired in a clinical setting. Do you recall saying that?

A. I don't specifically recall it, but I agree with it as you say it now. Do you mean in this deposition here or the affidavit?

Q. Yes.

A. I agree with the statement.

Q. Are you aware of case authorities which state that a lethal injection is not a medical procedure and is not held to those standards?

A. I think you mean by case authorities legal decisions?

Q. Correct.

A. Not specifically. I understand the

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general framework that you're talking about. I know legislatively some states have explicitly carved out the activity as being deemed a medical procedure. And I believe, although I can't think of any specific examples of courts where they do not view it as a medical procedure, but it's also my view that whether or not something is a medical procedure exists both as a legal point of view and also as a medical point of view. And this is an example of using medical procedures to carry out in ideally or the intention of a euthanasia, which is a medical procedure.

Q. So to the extent the courts have said that optimum medical standards do not need to apply in a lethal injection setting, you would disagree with those opinions?

A. I'm not sure that courts say that optimum medical standards don't need to apply. You have to give me a specific example.

Q. Well, that --

A. Optimum medical standards don't apply anywhere. They don't apply in medicine. It's always below optimum in medicine.

Q. But to the extent that courts have said that a lethal injection is not a medical procedure,

completely inappropriate to participate in the procedure, as has been evidenced in numerous lethal injection cases around the country.

Q. Now, in Baze, the Supreme Court believed that a provision requiring the hiring of a person with one-year professional experience, and let's talk about an EMT since that's what South Dakota has used, so an EMT with one-year professional experience with that provision was adequate. Do you know what South Dakota's protocol provides?

A. In terms of professional experience, two years.

Q. So South Dakota's protocol requires more experience than the Baze, than the provision approved in Baze?

A. Correct.

Q. Now, doctor, I would like to have something on the record here. Could you just explain anesthesia and particularly in this context. Let's say someone is given 5 gram dose of pentobarbital. What's the body going to go through, assuming that it's all successfully delivered, what's going to happen to the body?

A. The drug will enter the vein let's say

in the arm, it has to it is carried by the circulation to the heart. Heart actually has two sides, the right side and the left side. The right side of the heart will pump the blood through the lungs. The drug will thus be pumped through the lungs, and return to the left side of the heart. And then the left side of the heart will pump the blood which now has the drug in it throughout the body, including in the case of pentobarbital, the thing we're interested in is it being carried to the brain. So it will flow in the blood into the vessels in the brain and then it will travel out of the blood vessels across the wall of the blood vessels into the tissue of the brain. It will then bind or stick to molecules on the surface of neurons in the brain, and as a result of that those neurons will stop firing electrical activity. In the doses that are being talked about here, it all goes in and circulates as planned, that will shut down basically all electrical activity or all detectable electrical activity in the brain.

Q. Let me jump in here real quick. At what point does the inmate lose consciousness?

A. In the sequence that I gave, it's as the drug is passing from the blood vessels into the tissue

of the brain as it binds to the neurons it begins to depress the functioning of those cells and depress the electrical activity of the brain and the functioning of the brain. So that's the point where the brain begins to be disrupted and at some point the disruption becomes severe enough that consciousness is not sustained.

Q. Once the inmate loses consciousness the inmate no longer feels or is conscious of pain?

A. Well, that's not accurate. The person who's been rendered unconscious by a sedative or anesthetic drug, if they're not deeply anesthetized can be aroused by pain just as in an analogous way to how a sleeping person can be, sleeping in a conscious person can be aroused in that state and then experience pain.

Q. But that's more in the circumstance of a surgery where you've had a titrated dose. I'm talking about a 5 gram dose of pentobarbital here. No one is going to wake up from that, are they?

A. Right. I thought we were talking about, you asked me at what point in the process do they lose consciousness. During the process their loss of consciousness is initially minimal. They are not in a

state of deep unconsciousness where they're unarouseble. They're initially in a state of light unconsciousness where they can still be aroused. As the drug's concentration of the brain tissue increases their level of unconsciousness will get deeper and deeper and by that I mean will become increasingly difficult to arouse and then impossible to arouse.

Q. So certainly by the time that respiratory arrest takes place the inmate is in an anesthetic state of or surgical plane of anesthesia and no longer capable of being in pain or being consciously aware of being in pain?

A. I don't want to quibble about the language because you said at the point respiratory arrest occurs – what we see with pentobarbital is change in respiration. And then you don't know what the last breath is until some period of time after it is taken. So if you want to call respiratory arrest something where say 60 seconds to the time they're not breathing, and we'll call that respiratory arrest, then I'll agree with that, in this context. Right at the time where they're taking haking breaths or yawning or snoring, we don't know that's respiratory arrest until after the fact. When they are in that

anesthetist, for example, very few are able to do administering drugs and detect assessing levels of sedation and unconsciousness. And if they're properly positioned, they'll be able to know if things are done wrong.

Q. How about an EMT?

A. Again, we had EMT's in general typically are not specialized and experienced in assessing levels of sedation from anesthetic drugs, but it is an activity that they sometimes confront because sometimes they are called to a situation where a person has taken an overdose of drugs or alcohol.

Q. Well, the -- in the lethal injection setting, is the necessity of experience measuring anesthetic depth very important when you're only using a one-drug pentobarbital protocol?

A. You don't have to call it anesthetic depth, but being able to assess the level of intoxication, the level of sedation, the level of impairment of the nervous system functioning, yes, that's important.

Q. Why is that important if the inmate has stopped breathing within 60 seconds, why is it important for the EMT to have any further experience

with measuring anesthetic depth?

A. If in fact they have stopped breathing within 60 seconds then you're right there would not be a need for that in the case of the single-drug protocol using a barbiturate.

Q. But if they haven't stopped breathing --

A. You have to understand that shallow breathing can be missed by a person who is inexperienced. So this is sometimes a problem even in veterinary euthanasia, with inexperienced practitioners that they fail to recognize failed euthanasia procedure.

Q. If the procedure fails, what do you do?

A. If the procedure is in the process of failing, in other words, I presume you mean by that the prisoner is not dead, the procedure calls for more, for one more round of pentobarbital to be given.

Q. Right. You just give more drug until it takes, correct?

A. Not until it takes. They have set for one more round of drug and there's nothing specified for after that. And I think it would, everybody would agree if the first round hadn't worked then I would have to be very concerned that there was something

wrong with the drug itself or the administration of the drug that something was not going right if as we discussed if 5 grams didn't lead to comatose state with no breathing, did not lead to death, then something is wrong in the process somewhere.

Q. So if the first round didn't take it might be because there was infiltration and not an inadequate dose --

A. It could be --

Q. Just answer the question I asked. That might be one reason that the drug didn't work because it infiltrated --

A. Circulation, yes.

Q. And another reason might be because the drug wasn't sufficiently potent?

A. Correct.

Q. Any other reason?

A. The tubing leaked somewhere, so it's not on the tissue, it's on the floor.

Q. But people are going to see if there's a puddle of medication on the floor, right?

A. I don't know. They might miss it. I don't know if it's leaking from right at the hub and going down the side of the wrist and onto the gurney

then you might not see it.

Q. So those are the three possibilities for why the inmate might not expire as quickly as you would expect. It could be because there's leakage, there is a sub-potent drug or infiltration?

A. We're talking about things going wrong. They didn't inject the dose, they decided to take half of it home and have fun with it. Or the powder that was, they thought they were mixing was, or the solution they thought they had was pentobarbital could be substituted by someone who wanted to take it home and have fun with it. There are a variety of ways that fix what one is actually doing.

Q. But in terms of the adequacy of the protocol, doctor, that's what we're talking about here, the protection afforded by first of all the presumption that people are going to do their jobs, and the amount of drug that is called for in the protocol, namely 5 grams, those protections would provide reasonable assurance that the individual would be executed by a humane and painless process, would you agree?

A. Pretty broad question with a lot of compounds, but I certainly agree if the protocol is

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

VERNON EVANS, JR.,
Plaintiff
v.
MARY ANN SAAR, Secretary, Department of Public Safety and Correctional Services, FRANK C. SIZER, JR., Commissioner, Maryland Division of Correction, LEHRMAN DOTSON, Warden, Maryland Correctional Adjustment Center, GARY HORNBAKER, Warden, Metropolitan Transition Center and, JOHN DOES,
Defendants
: CIVIL ACTION NO. L-06-149

* * *

August 29, 2006

* * *

ORAL DEPOSITION of MARK HEATH, M.D., taken pursuant to notice, held at the Law Offices of Wilmer, Cutler, Pickering, Hale & Dorr, LLP, 399 Park Avenue, New York, New York, commencing at 11:27 a.m., before Renee Schumann, Court Reporter - Commissioner of Deeds there being present:

EXHIBIT 9

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Q. Let me ask you this, do you agree with that or not?
A. I would need to see the context in which it was said. The definition of death is -- there are many operating definitions of death, and so for it -- I agree that it would -- if three grams of Thiopental were effectively delivered into the circulation it would kill the person. Would they be dead in 60 seconds, I, in just a general proposition, disagree with that, but I need to see the context of how the language was phrased.
Q. Okay.
A. If he didn't do anything to resuscitate them, they would with certainty die. It's a lethal dose of Thiopental. In terms of when they are dead, I think 60 seconds is on the early side for the majority of human beings.
Q. Well, you've seen Dr. Dershwitz's report; haven't you?
A. Yes.
Q. And Dr. Dershwitz says that there's a

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good possibility that an individual who is given three grams of Thiopental could be -- could be dead within 60 seconds?
MS. GERAGHTY: And again, I am going to object to you asking him questions about --
THE WITNESS: I don't recall him specifically saying that in his report, but I think that's similar to what I'm saying, in some people it could stop their heart basically as soon as it's perfused with the muscle of the heart, which depending on the rate of injection, all that kind of stuff, could be 60 seconds.
But I also think that in many -- and I had said it before getting evidence, before actually seeing EKG records and stuff like that, I could have gone along with that statement, but now I've seen evidence that doesn't -- would not normally be available or isn't available to other people that leads me to disagree with a sweeping statement that it

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would certainly cause death in 60 seconds in everybody.
BY MS. MULLALLY:
Q. Do you think it would take a little longer perhaps in some people?
A. I'm sure that it does take longer in many -- in most people.
Q. All right. Now, you don't mention in your report at all titration of any of the drugs?
A. I think that's right, yes.
Q. Do you think titration is at all relevant in lethal injection since the goal is to execute the individual?
A. Could you define what you mean by titration?
Q. Changing or selecting an amount of a drug given based on an individual's sex, height, weight, age, things like that?
A. It's slightly complicated. If you want to get every prisoner the identical safety margin then you would need to factor in those types of

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things that you mentioned. If you don't care about doing that, it is, in my opinion, reasonable to give a dose that if it's effectively delivered will ensure a surgical pint of anesthesia in everybody.
By not titrating what happens is if something occurs, if not all of the dose goes in, then you put some groups at more risk than others.
Q. Now, do you believe that the injection of the potassium chloride stops the heart and kills an inmate in a lethal injection situation; is that correct?
A. In the great majority of executions that is what actually stops the heart, it's the potassium.
Q. And why do you believe that?
A. From reviewing EKG records and in conjunction with witness descriptions and logs hard data, the best data that we have from executions, which again, is not collected in my opinion in a good scientific fashion, but it's the best we have and it's pretty good.

Westlaw.

2009 WL 6686346 (S.D.Ohio)

For Opinion See 2011 WL 2681193 , 2011 WL 320166 , 2010 WL 3769213 , 2010 WL 3238972 , 2010 WL 3212079 , 2010 WL 1882263 , 2010 WL 1610608 , 2010 WL 1434312 , 2009 WL 4842393 , 610 F.Supp.2d 853 , 72 Fed.R.Serv.3d 161 , 2008 WL 4411391 , 2008 WL 4411393 , 2008 WL 4411395 , 2008 WL 4065811 , 2008 WL 4065812 , 2008 WL 4065808 , 2008 WL 4065809 , 2008 WL 4065813 , 2008 WL 4065815 , 2008 WL 4065826 , 2008 WL 4065828 , 2008 WL 4065830 , 2008 WL 4065832 , 2008 WL 4065833 , 2008 WL 4065836 , 2008 WL 4065838 , 2008 WL 4065841 , 2008 WL 4065842 , 2008 WL 4065844 , 2008 WL 4065862 , 2008 WL 4065876 , 2008 WL 471536 , 2007 WL 2688249 , 2007 WL 2607583 , 2007 WL 1831115 , 2007 WL 1202718 , 2007 WL 582486 , 2007 WL 582490 , 2006 WL 3762133 , 2006 WL 3526424 , 2006 WL 3391001 , 2006 WL 3793308 , 2006 WL 3043116 , 2006 WL 2709775 , 2006 WL 1705177 , 430 F.Supp.2d 702 , 2005 WL 5253337

United States District Court, S.D. Ohio,
Eastern Division.
COOEY,
v.
STRICKLAND, et al.
No. 2:04-CV-1156.
March 26, 2009.

Testimony of Mark Heath, M.D.

Case Type: Civil Rights & Constitutional Law >> Section 1983
Jurisdiction: S.D.Ohio
Name of Expert: Mark J. S. Heath, M.D.
Area of Expertise: Health Care-Physicians & Health Professionals >>Anesthesiologist
Representing: Plaintiff

Appearances of Counsel:

For the Plaintiff: Timothy F. Sweeney, Esquire
John P. Parker, Esquire.

For the Defendant: Charles L. Wille, Esquire.

Before the Honorable Gregory L. Frost United States District Judge.

COLUMBUS, OHIO

(VOLUME I)

EXCERPT OF TRANSCRIPT OF PROCEEDINGS

Denise N. Errett, RMR, CRR

Official Court Reporter

85 Marconi Boulevard

Room 260

Columbus, Ohio 43215

(614) 719-3029.

TABLE
THE COURT: All right. Mr. Sweeney, you may begin your direct examination.

MARK HEATH, M.D. AFTER HAVING BEEN FIRST DULY SWORN, TESTIFIED AS FOLLOWS:

DIRECT EXAMINATION

BY MR. SWEENEY:

Q. Good afternoon, Doctor. Please state your name.

A. Mark Heath.

Q. What do you do for a living?

A. I'm an anesthesiologist.

Q. And where at?

A. In New York City, at Columbia University.

Q. Tell the Court, if you would, about your -- you

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Q. That kind of transparency, do you see that in other states, at least some transparency where you can review the process to know whether the execution was, you know, what -- medically at least make some judgment as to whether it was humane or not?

A. Well, there are states where I believe there is a conscientious physician assessing anesthetic depth throughout. That doesn't prove that they're not deliberately misleading, but I am willing -- you know, I fully accept that a conscientious physician is going to be doing their job and ensuring that the prisoner is anesthetized.

Is it a total guarantee? No. There are no guarantees in life on anything, but I think it certainly meets any reasonable standard.

Q. The issue of transparency, though. And what are the things you, as a physician, would need to know or want to know so that you can make a judgment as to -- reliable judgment within the scope of, you know, reasonable human endeavor as to whether or not an execution is being carried out in a way that's humane, a person is not suffering pain from it?

A. You're talking about a hypothetical. If I were to review an execution record and there was an EKG tracing showing that the heart rate hadn't gone up and blood pressure is showing that it had not gone up -- it probably would have gone way down if the thiopental got in -- and a person who understood how to assess anesthetic depth had been observing the procedure, then I would be comfortable that -- even though the prisoner was paralyzed, I would be pretty comfortable that they had had a humane execution. I can look at an anesthesia record and could be pretty comfortable that the patient was properly asleep, or see that they weren't asleep.

It's much more difficult with pancuronium. If you really want transparency, you should do it like the veterinarians do it, where they don't use a paralyzing drug. If the dog or the cat is in pain or suffering, it will struggle or bark or move in some way, and the owner of the pet will see that. The veterinarian will see that and will fix it. That's why veterinarians don't use pancuronium. That's why, in Ohio, animal shelters aren't allowed to use paralyzing drugs. It's because they don't want to mask that problem.

Q. It's your understanding that that restriction on veterinarians, is that a statutory one, or do you know?

A. I know animal shelters in Ohio are only allowed to use pentobarbital, which is -- you can think of pentobarbital like Pentothal, except that instead of wearing off quickly, it lasts for a very, very long time, which makes sense. You want the animal to be dead. So it makes sense to use something long-acting. They're not -- animal shelters don't use anything other than that. At least they're not supposed to in Ohio.

Q. Could the use of one drug, such as in the euthanasia context involving animals, could that, in your opinion, be effectively used in an execution setting?

A. What works for all other vertebrate animals, all other mammals, is going to, in massive overdoses, is going to work in human beings also.

Q. Do you have any sense as a medical professional as to how long an execution would take using massive doses of sodium thiopental?

A. Which would be the same as using massive doses of some other anesthetic. Yeah.

Q. True.

A. The reason one would die in that context is going to be because of not breathing. The drug will take away the respiratory drive. And in a healthy person, I think that would take probably around ten minutes. It's very variable. You will have severe brain injury and brain death after around four minutes. And, so, a person could be considered brain dead before their heart actually stops working because their brain would have -- all the neurons in

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their brain would have died irreparably, and that's brain death. And that's legal death, also. It will take longer, probably, for the heart to stop having electrical activity.

Q. Christopher Newton's execution, it appeared, took what, according to that chart, anyway, based on the timeline? Do you see that? I think it's the last column.

A. I think it's 14 minutes.

Q. In your opinion, would the use of one drug, massive dose of sodium thiopental or some other barbiturate, take more or less time than that?

A. If you -- you know, if you give a massive dose of pentobarbital, which can be done very quickly, in all likelihood the person is going to be legally dead in less time than that.

THE COURT: Well, you keep changing. He keeps talking about sodium thiopental, and you keep saying -- I guess -- excuse me -- what I'm reading from you is that you would suggest going to that other drug?

THE WITNESS: I'm uncomfortable suggesting things, as a physician, proactively designing a protocol, because professional ethics --

THE COURT: What do you think you're doing here?

THE WITNESS: Well, I'm trying to -- that's a very good question, and it's difficult. I am trying to, you know, say what I think the main problems are, but in terms of giving specific recipes, I will -- in terms of the difference between pentobarbital and thiopental that you're asking about --

THE COURT: That's right.

THE WITNESS: -- thiopental is given in large volumes, and so it takes a long time. It can take longer to get it in. One can give a comparable or a larger dose of pentobarbital more quickly. So that affects how the timing would unfold.

BY MR. SWEENEY:

Q. With the dose, massive dose, of whichever drug, sodium thiopental, pentobarbital, whichever one is used, if that is used in place of a three-drug protocol, in your opinion, the I.V.-access issues and infiltration issues, are those problems any longer?

A. If all you're using is an anesthetic-only technique, which is what veterinarians use --

Q. Right.

A. -- the chance of causing an inhumane death is exceedingly remote. Again, you're using a drug that all it does is make you get sleepy and then make you go to sleep and then make you stop breathing and make you die. The worst that could happen is you don't get enough in right away, which is what happened to Mr. Clark, or whatever, and you give more, and you give more until the person does get sleepy and until they do die. That's really the worst thing that can happen.

Without -- if you remove the drugs that can cause excruciating pain, there's no way of having excruciating pain, or any pain. You still have to worry about getting the I.V. in. You know, what happened to Mr. Clark should never have happened, that his neck was being needled, especially when he was sitting up. You have to worry about those things also, but in terms of the drugs that you use, if you just use a massive overdose of an anesthetic, it will stop the breathing, and it will cause death, and it will not be able to cause pain, because all anesthetics do is make you go to sleep.

Q. The pancuronium, does it perform any medical function at all in an execution?

A. No medical function whatsoever.

Q. Back to the protocol. I want to wrap that up. Does the Ohio protocol address the contingency for what to do in the event peripheral I.V. access is un-

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Q. But you mentioned toxicology, Doctor. In fact, didn't you say in your deposition that the toxicological reports that you have examined indicates that in most circumstances an adequate dosage of thiopental was administered? Did you not say that?

A. In other states, yes, in the states where I'm able to look. So, again, many states, you can't use the numbers. But in the states where I can use the numbers, most of the time they are.

Q. And didn't you say in your deposition, in fact, that you spoke to a laboratory technician or a laboratory director in North Carolina, and he indicated to you that the samples, the toxicological reports from those samples taken, the samples on which those reports were based, were improperly drawn and couldn't be used to do scientific conclusions?

A. That's not exactly what he said. That's why I don't use numbers from North Carolina to draw robust conclusions.

Q. And you are aware, Doctor, that this court, in previously granting a preliminary injunction, thought that the North Carolina possible evidence of improper thiopental was a significant piece of information, which it was at the time? Are you aware of that?

A. I've been told by attorneys that that was one of the issues you had raised. And I think I saw it in a motion to dismiss or some such motion that you wrote, and that's exactly why I did my very best, both before and after the publication, to try to express the concern that I have about those numbers.

Q. Isn't it true, Doctor, that you're opposed to the death penalty? That's true, isn't it?

A. Yes.

Q. And isn't it true that, because you're opposed to the death penalty, you don't really need any substantial evidence that inmates suffered severe pain in order to testify or render an expert opinion that there's a risk that they could?

A. That's completely untrue. Again, if Ohio were to use a veterinary standard of lethal injection or to bring in a experienced professional who could ensure anesthetic depth when the prisoners are paralyzed and being given potassium, then there would be no litigation, or at least I would not participate in the litigation, or I would work for your side to say that I think this is a safe and humane procedure.

Q. Isn't it true, Doctor --

THE COURT: They can't afford you.

THE WITNESS: Dr. Dershwitz charges more. So --

MR. WILLE: Thank you, Your Honor. I have no more questions.

THE COURT: Thank you. Actually, it doesn't matter. It's all fungible, I think.

MR. SWEENEY: One question?

THE COURT: Yeah. You said one.

MR. SWEENEY: I think it will be one.

REDIRECT EXAMINATION

BY MR. SWEENEY:

Q. You were about to describe three factors you use to assess substantial risk. Explain to the judge your three factors and how you apply it.

THE COURT: Yeah. That's never been testified to.

MR. SWEENEY: I don't think it has.

THE COURT: No, it has not. No. I said it has not been testified to, but it was brought up on cross.

BY MR. SWEENEY:

Q. Could you go ahead and explain the three factors?

THE COURT: The asteroid hitting the foot, apparently, something going on there. I haven't quite

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In The Matter Of:

RONALD ALLEN SMITH, et al. v.

STATE OF MONTANA, et al.

MARK J.S. HEATH, M.D.

April 28, 2015

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MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS AND CLARK COUNTY

RONALD ALLEN SMITH AND WILLIAM J. GOLLEHON, Plaintiffs, v. STATE OF MONTANA; DEPARTMENT OF CORRECTIONS; DIRECTOR MIKE BATISTA; WARDEN LEROY KIRKEGARD; JOHN DOES 1-20, Defendants.	Cause No. BDV 2008-303

April 28, 2015
6:00 p.m.

TELEPHONIC DEPOSITION of the EXPERT WITNESS, MARK J.S. HEATH, M.D., held at 67 Riverside Drive, New York, New York, before Cynthia Zoller, R.P.R., a Notary Public within and for the State of New York.

* * *

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- Mark J.S. Heath, M.D. -

M A R K J. S. H E A T H , M . D . ,

Expert Witness herein, having affirmed before Cynthia Zoller, R.P.R., a Notary Public within and for the State of New York, was examined and testified as follows:

THE REPORTER: Please state your name for the record.

THE WITNESS: Mark J.S. Heath, M.D.

THE REPORTER: Please state your address for the record.

THE WITNESS: The office address is 630 West 168th Street, Department of Anesthesiology, Columbia University, New York, New York 10032.

MS. COLLINS: For the record, my name is Pamela Collins. I'm an Assistant Attorney General for the State of Montana, representing the defendants.

MR. WATERMAN: My name is Ron Waterman. I'm the attorney in Helena, Montana representing the

that typically happens, and maybe this paragraph comes from an introductory chapter, I'm not sure.

Q Okay. If you'll take a look at the last sentence of that paragraph at the top of the Exhibit 1, it states that, "Lastly, the author believes in the importance of disclosing that, as a result of his involvement in the legal challenges to lethal injection, he has developed a strong opposition to the imposition of the death penalty as it is presently administered in the United States."

Did I read that sentence accurately?

A I think so, yes.

Q Is that a true statement in terms of you, as far as you are concerned?

A It's a lot more complicated than that, but then it can then be distilled into one sentence and it also reflects my views, this looks like it was written in 2007, so those were my views eight years ago, approximately.

patients it might be reduced as low as 100 milligrams and for some patients it might go up to 400 milligrams, in sometimes more large and more resistant patients, 400 or more.

Q And Dr. Heath, for the thiopental how long did it take for, how long was the time of the onset of action for thiopental when you used it in your work as an anesthesiologist?

A To break it down, the amount of time that elapses between the injection and the first evidence that it's taking effect in the brain is quite variable. It depends on the speed or the rate of the patient's circulation, among other things so an average patient might be in the realm of 20 seconds, 20 to 30 seconds; a patient with a slower circulation because of heart failure or some other problem could be well over a minute and again that's the time it takes for the drug to reach the brain and obviously, it's not exerting any effects on the brain until it reaches the brain so

that is below the dose needed to exert the desired effect, in this instance would be unconsciousness, then the rate at which one moves towards unconsciousness will be lower and one will never achieve it.

If one gives a dose higher than, as with most drugs, the more one gives, the more rapidly one sees the effects.

Q And you say this is true of all barbiturates or all drugs in general or, or --

A Well, maybe not of all drugs, because some drugs you don't see the effects for days or longer so the speed with which you give it, whether you give it one minute or five minutes or the dose which you give it will still leave it, will still make it that it only starts to work in several days and perhaps, one wouldn't notice a difference, but I think, let's confine this to what we are talking about, thiopental, which is trying to induce unconsciousness. I think it's fair to say I can't think of an exception right now, that all drugs that are

- Mark J.S. Heath, M.D. -

used to produce sedation and unconsciousness will exert their effects at a more rapid rate if you give more and to clarify again, giving more will not have a substantial or any material effect on how long it takes for the drug to travel from the point of injection to the brain.

What I'm talking about is the onset and that transition from being fully conscious to being fully unconscious.

Q Dr. Heath, if you'll take a look at State's Exhibit 2.

A Yes.

Q This is a five-page document dated April 30th, 2013, which begins with the words, "I, Dr. Mark Heath, hereby declare as follows:" Do you recognize this document?

A Yes.

Q And is that your signature on the last page of the Exhibit 2?

A Yes, it is.

Q Dr. Heath, looking at Paragraph 10 in Exhibit 2, in the second sentence you state: "Pentobarbital has a slower onset

- Mark J.S. Heath, M.D. -

Q You state in that state -- in that sentence in your declaration that I just read, "in many instances, prisoners display a more prolonged period of movement after the drug starts to take effect" and you are referring to pentobarbital versus thiopental. How many instances are you referring to there?

A I need to be approximate and say several tens; 10, 20, 30, I don't know. It's the typical description from a pentobarbital execution that the prisoner breathed for a longer period of time, may have uttered some words that may or may not have been coherent, may have moved their body in a variety of ways and those things are extremely uncommon in thiopental executions and I should just give one exception; there are some states that give the thiopental very, very slowly over a period of many minutes and in those cases as one would expect, that onset transition is a lot slower, but that's not because the drug is, because of the aspect of the drug, it's

to and another one was not and I don't recall which one I looked at, to be honest.

Q Could you tell me what the time of onset of action would be when 3 grams of thiopental is properly administered intravenously?

A At what rate?

Q Could you give me a range depending on the rate?

A At a very slow rate it would take hours. At its fastest possible administration, it would take some tens of seconds to transition from full consciousness to full and deep unconsciousness.

Q And I'm sorry, what -- I'm getting mix up with tens or tenths.

A Tens. I'm sorry, there are no tenths in this discussion.

Q So it's tens?

A Tens, yes.

Q So tens of seconds?

A Yes. And I just have to be clear, I've not had the opportunity to be

time, but does not die because the drug hasn't been fully, hasn't been delivered into the circulation, just into the tissue, and emerges with brain damage, which would be an inhumane and disastrous outcome.

That is less likely to happen if thiopental or another ultrashort acting drug is used, because in that circumstance, the prisoner will not attain a high enough level in their blood to render them unconscious and make them stop breathing and sustain brain damage so again the concern centers on the executions which inevitably occur where the drug or drugs are not delivered into the venous system and into the circulation, but instead, are infiltrated into the tissues surrounding the IV catheter.

Q But Doctor, assuming proper administrations of the drugs, what would be your response?

A If proper administration of the drug occurs, whether it is thiopental or pentobarbital, if proper administration occurs in the intended multi-gram dose into

the circulation and carried to the brain, then there's no difference between the drugs, because they will both produce deep unconsciousness that will outlast the duration of the execution.

The problem centers around the inevitable occurrence of improper or failed administration.

Q Doctor, what is the dividing line between the classification of ultrafast barbiturates and fast barbiturates; is it a time dividing line or where do we draw the line between those two or where do medical people draw the line between those two?

A Well, the line is really a molecular line. The molecules that have been modified to have this property of very rapidly crossing membranes is a discreet group from the rest of the barbiturates, because they don't have that modification or those modifications. Those modifications have created a class unto itself, this ultra class, which is not surpassed or exceeded in that property of rapidly crossing a membrane

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH DAKOTA
SOUTHERN DIVISION

DONALD E. MOELLER, Petitioner, v. DOUGLAS WEBER, Warden, South Dakota State Penitentiary, Respondent.	Civ. 04-4200 AFFIDAVIT OF WARDEN DOUGLAS WEBER

State of South Dakota)
: ss.
County of Minnehaha)

I, Douglas Weber, being first duly sworn upon oath, testify, based on personal knowledge and belief, as follows:

1. I was appointed to serve as Warden of the South Dakota State Penitentiary program (hereinafter SDSP), located in Sioux Falls, South Dakota, on November 19, 1996, by then Secretary of Corrections, Jeff Bloomberg. In my capacity as Warden, I have, pursuant to SDCL 24-2-1, charge and custody of all inmates confined in the SDSP.

2. Among the inmates under my charge and custody are those sentenced to death under SDCL ch. 23A-27A. In South Dakota, the punishment of death shall be inflicted by lethal injection. SDCL 23A-27A-32. Statute, as amended July 1, 2007, provides that, as Warden, I shall determine, subject to the approval of the Secretary of the South Dakota Department of Corrections (hereinafter SDDOC), the substances and the quantity of

EXHIBIT
tabbies 12

substances used for the punishment of death. Prior to July 1, 2007, SDCL 23A-27A-32 provided for a two drug combination of substances to execute a death sentence, specifically, "The punishment of death shall be inflicted by the intravenous administration of an ultra-short-acting barbiturate in combination with a chemical paralytic agent and continuing the application thereof until the convict is pronounced ...".

3. In order to fulfill that responsibility, I, along with various members of my staff, undertook to adopt and implement, effective June 14, 2007, Emergency Response Manual A.12 entitled "Capital Punishment Final Days Procedures," (hereinafter ERM). As provided therein, I elected, with the approval of the Secretary of Corrections, to adopt the three drug protocol used by at least thirty other states, along with the federal government to execute prisoners. The ERM further provided, in accordance with SDCL 23A-27A-32.1, that those inmates sentenced to death prior to July 1, 2007, had the option of choosing to be executed using the three drug protocol or a two drug protocol consisting of an ultra short acting barbiturate in combination with a chemical paralytic agent.

4. Under the three drug protocol adopted in the aforementioned ERM, the lethal injection process involved the administration of chemicals as follows:

1. The first syringe contained three grams of sodium thiopental, an ultra short acting barbiturate, along with approximately thirty milliliters of a solution of sterile water;

2. The second syringe contained fifteen to twenty-five milliliters of saline to flush the IV line and to prevent any interaction between the first and second drug;

3. The third syringe contained one hundred milligrams of pancuronium bromide, a chemical paralytic agent, along with approximately fifty milliliters of a solution of sterile water;

4. The fourth syringe again contained fifteen to twenty-five milliliters of saline to flush the IV line; and

5. The fifth and final syringe contained not less than 140 milliequivalents of potassium chloride, used to stop impulses to the heart, along with a solution of approximately seventy milliliters of sterile water.

Before carrying out the intravenous injections, I made every effort to ensure that the person administering those injections was adequately trained to do so.

5. The guidelines established by the American Medical Association prohibit physician participation in executions. State statute, therefore, provides that "the person administering the injection need not be a physician, registered nurse, or licensed practical nurse licensed or registered under the laws of this or any other state." SDCL 23A-27-32. As provided for in the 2007 ERM, I selected, with the approval of the secretary of the SDDOC, an executioner and a backup executioner trained to administer intravenous injections. As in Taylor v. Crawford, 487 F.3d 1072, 1082 (8th Cir. 2007), the IV team consisted of contracted medical personnel.

6. The aforementioned ERM was in place at the time of the Elijah Page execution on July 11, 2007. In accordance therewith, the individual I selected to insert the IV lines into inmate Page at the time of his execution had been a licensed/certified paramedic for over fifteen years and was trained and experienced in IV insertion.

7. According to eyewitnesses to the execution of Elijah Page, it was carried out in accordance with the established protocols and was described as being "done by the book and a bit like clockwork." Attachment A, Minnesota Public Radio. As indicated by Carson Walker, a reporter for the Associated Press, "it was just a matter of seconds . . . the next thing we heard were several gasps, it was almost like a snoring, and his chest heaved a couple of times."

8. A similar account was also given by Bill Harlan, *Rapid City Journal*, who was another eyewitness to the Page execution. In an article written for the *Rapid City Journal*, Mr. Harlan stated "Page never moved. Not his head, not his arms, not his feet." According to Harlan, inmate Page "gasped slightly. His chest heaved, but only a little, and he exhaled with what sounded like a snore." Attachment B.

9. Affiant remained in the execution chamber with inmate Page at all times during the scheduled execution. At no time whatsoever did I observe inmate Page display any signs of pain during his execution on July 11, 2007. There was no evidence of inmate Page crying out, writhing in pain, gasping for breath or otherwise moving during the execution process.

10. In the case of inmate Page, death occurred within a matter of minutes after the aforementioned chemicals were administered. Affiant believes that this clearly attests to the experience and efficiency of the executioners chosen to assist in carrying out the scheduled execution of inmate Page. Inmate Page's execution was carried out in accordance with the

established ERM and resulted in what appeard to be swift and painless a death as possible.

11. Subsequent to the execution of Elijah Page, Affiant learned, in discussions with legal counsel for the SDSP and the SDDOC, that the United State Supreme Court upheld the lethal injection protocols adopted by the Kentucky Department of Correction, Baze v. Rees, 553 U.S. 35, 128 S.Ct. 1520, 170 L.Ed.2d 520 (2008). In addressing further challenges to the lethal injection protocols adopted by other states, the Court held "a state with a lethal injection protocol substantially similar to [Kentucky's] . . . would not create a substantial risk of pain rising to the level of an Eighth Amendment violation." Clemons v. Crawford, 585 F.3d 1119, 1126 (8th Cir. 2009) (citing Baze, 553 U.S. at 61, 128 S.Ct. at 1537.

12. Affiant, in consultation with legal counsel, thereafter undertook to determine, in light of Baze, what, if any, changes to the then existing ERM would even further reduce what I believed to be an already remote possibility that a condemned inmate would experience any unnecessary pain during an execution by lethal injection. In doing so, Affiant also reviewed and relied on decisions from the Eighth Circuit Court of Appeals upholding, as constitutional, the lethal injection protocols adopted in Arkansas and Missouri. Clemons, 585 F.3d at 1128; Nooner v. Norris, 594 F.3d 592 (8th Cir. Ark. 2010).

13. Based on my consultations with counsel, as well as my review of the aforesaid case law, Affiant revised the ERM on August 12, 2010. Under the

revised protocols, the substances and quantity of substances used to inflict the punishment of death remain the same and have, pursuant to SDCL 23A-27A-32, been approved by the Secretary of Corrections. Those revisions incorporated yet additional safeguards to even further insure that the condemned inmate has been rendered unconscious by the proper administration of the first chemical, sodium thiopental, and thereby eliminate risks, however slim, that the inmate would experience any pain associated with the administration of pancuronium bromide and potassium chloride.

14. As amended, the current ERM goes even further than the Kentucky protocols approved in Baze and requires that members of the IV team responsible for establishing an IV infusion site have at least two years of experience as a medical or osteopathic physician, physician assistant, registered nurse, licensed practical nurse, certified medical assistant, phlebotomist, paramedic, emergency medical technician or military corpsman.

15. The amendments to the lethal injection protocols also include increasing the length of the interval between administration of the first and second injections. Under the protocols as they existed in 2007, "to assure the sodium pentothal has taken affect and the condemned is unconscious, there will be a pause before administering the next injection of approximately two minutes after the second injection is completed." That "pause," under the revised protocols, has now been increased to three minutes.

16. During that three-minute time period, Affiant and/or his designee will, using standard medical techniques such as checking the inmate for

movement, open eyes, eyelash reflex, and response to verbal commands and physical stimuli, verify that the inmate has indeed been rendered unconscious by the administration of the thiopental.

17. Affiant and/or his designee will also continuously monitor the primary infusion site for signs of any problem such as obvious swelling caused if the IV fluids or chemicals were to infiltrate into the tissue surrounding the IV site. If Affiant has any reason to believe that the primary IV site is not working or has become obstructed, I will immediately direct that the flow of chemicals be stopped to the primary IV site. The executioner would thereafter be instructed to administer an additional three (3) grams of thiopental to the inmate using the secondary or backup IV site.

18. Moreover, if Affiant, after that three-minute interval, has reason to believe that the inmate remains conscious, I and/or my designee will direct the executioner to administer the backup dose of sodium thiopental using the secondary IV line. The remaining chemicals, pancuronium bromide and potassium chloride, will be administered only after confirmation that the prisoner is unconscious and after a period of at least three minutes have elapsed from the injection of thiopental.

19. Affiant believes that these additional safeguards serve to even further insure that the thiopental is properly administered to the condemned inmate and thereby eliminate the possibility, however slim, that the inmate will experience any unnecessary pain resulting from the administration of pancuronium bromide and potassium chloride.

20. In the case of an inmate convicted and sentenced to death prior to July 1, 2007, who chooses, pursuant to SDCL 23A-27A-32.1, to be executed in the manner provided by South Dakota law at the time of his conviction and sentence, the current ERM adopted by Affiant includes a "two drug protocol," approved by the Secretary of Corrections, consisting of the administration of three (3) grams of sodium thiopental along with fifty milligrams of pancuronium bromide. Affiant believes that this will alleviate any concern by inmate Moeller that he may experience excruciating pain caused by the potassium chloride. Clemons, 585 F.3d at 1124 (citing Taylor, 487 F.3d at 1074). An inmate electing to be executed using this two drug protocol will be able to avoid any alleged risk said to be associated with the third drug, potassium chloride.

21. As with the "three drug protocol," Affiant will, after administration of the sodium thiopental, wait for a period of at least three minutes before directing the executioner to commence administering the pancuronium bromide. During this interval, Affiant and/or his designee will again assess the inmate for any signs of consciousness using the aforementioned standard clinical techniques. If it appears to Affiant that the inmate still remains conscious within the three minutes after administering the thiopental, I will order that the flow of chemicals to the primary IV site be stopped. The executioner will then be directed by Affiant to administer an additional three (3) grams of thiopental to the inmate using the backup IV.

22. Affiant, along with the IV team, will continuously monitor the IV and infusion site. If there is any sign of infiltration or other problem with the IV site, Affiant will once again direct the executioner to stop the flow of chemicals to that site and resort to the use of the backup IV.

23. The executioners will commence the flow of pancuronium bromide only after Affiant and/or his designee has confirmed that the inmate has been rendered unconscious by the administration of the thiopental. If, after ten minutes following the administration of the pancuronium bromide, the person responsible for pronouncing death is not able to do so, Affiant will order the executioner to administer a second set of chemicals as described above.

24. Affiant is convinced that an inmate executed pursuant to the current ERM will not face any foreseeable risk of unnecessary pain during his/her execution. The ERM was revised by Affiant to eliminate any substantial risk of harm to the inmate undergoing a death by lethal injection in South Dakota.

Dated this 23 day of August, 2010.

Douglas R. Weber

Douglas Weber, Warden
South Dakota State Penitentiary

Subscribed and sworn to before me this 23rd day of August, 2010.

Patsy Mikel

Notary Public- South Dakota
My Commission expires: 6/16/2016

(SEAL)

PATSY MIKEL
NOTARY PUBLIC
SOUTH DAKOTA

X3

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH DAKOTA
SOUTHERN DIVISION

DONALD E. MOELLER,	*	Civ. 04-4200
Plaintiff,	*	
v.	*	AFFIDAVIT OF DOUGLAS WEBER
DOUGLAS WEBER, Warden, South Dakota State Penitentiary, **DENNIS KAEMINGK,** Secretary of the South Dakota Department of Corrections, and **DOES 1-20,** unknown employees or agents of the South Dakota Department of Corrections,	*	
Defendants.	*	

State of South Dakota *
* ss.
County of Minnehaha *

I, Douglas Weber, being first duly sworn upon oath, testify on personal knowledge and belief as follows:

1. I am the warden of the South Dakota State Penitentiary. In that capacity I carried out the execution of Eric Donald Robert on October 14, 2012. Robert's execution was performed using compounded pentobarbital.

2. I was in the execution chamber standing at Robert's right shoulder during the entire execution. Once Robert made his last statement, I signaled the executioners in the chemical room to commence the injection.

3. Robert remained conscious for only 45 seconds following my signal. He thereafter lost consciousness, expelled a snore, and remained unconscious until he was pronounced dead by the coroner. Robert expelled his last breath approximately 90 seconds after I signaled to commence the injection. After approximately 10 minutes, Robert's pulse ceased. After approximately 20 minutes, all electrical activity in Robert's heart ceased and he was pronounced dead by the coroner. A copy of the official timeline is attached. A copy of the official timeline is attached.

EXHIBIT
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4. Robert exhibited virtually no signs of pain or physical distress during either the seconds he remained conscious after the injection commenced or during the period of unconsciousness before he died. Media witness accounts describing the execution as "rapid," "swift," and "painless" are accurate. Robert's lawyer's description of the execution as "orderly," "polished," and "peaceful" also accurately describes the event. Copies of these accounts are attached.

5. Donald Moeller will be executed with the same drug via the same protocol as Robert. Due to the then-pending litigation, I ordered that the drugs for Moeller's execution be tested. The pharmacist had the drugs tested by an independent lab. The testing informs me that the drug intended for use in Moeller's execution has passed authoritative USP standards for purity, potency, and sterility. A copy of the testing report is attached.

Dated this 22nd day of October 2012.

Douglas Weber

Subscribed and sworn to before me this 22nd day of October 2012.

Notary Public- South Dakota

(SEAL)
My commission expires: 6/16/16

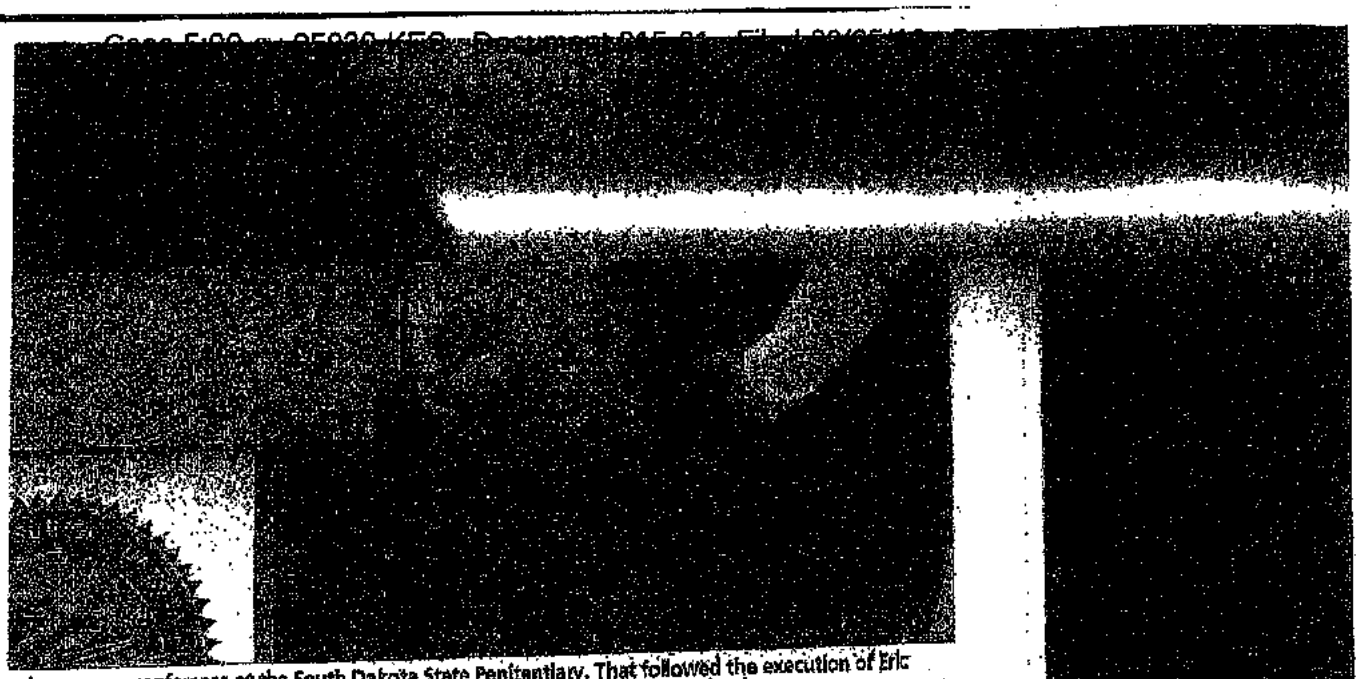
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Execution Timeline Record

Inmate name: **Eric Robert** Inmate number: **# 56564**

Execution Date: 10/15/12

1. Removed from holding cell — Time: 9:31 pm
2. Transferred to table — Time: 9:38 pm
3. Restraints secured — Time: 9:35 pm
4. IV started — Time: Right arm 9:37 pm
   Left arm 9:41 pm
   (Note whether arm, leg, or other)
5. Begin escorting witnesses to viewing rooms — Time: 9:46 pm
6. All witnesses present, Warden orders curtains opened — Time: 9:53 pm, 9:59 pm
7. Secretary of Corrections informs Warden that he/she is cleared to proceed with the execution — Time: 10:00 pm
8. Last statement — Time: 10:01 pm
9. Injections begin — Time: 10:01 pm
10. Injections completed — Time: 10:04 pm
11. Second set of injections required? ___YES ✓NO
    a. If yes, time second injections were started. Time:_____
    b. Time second injections completed. Time:_____
12. Time death was pronounced — Time: 10:24 pm
13. Curtains closed — Time: 10:25 pm



uring a news conference at the South Dakota State Penitentiary. That followed the execution of Eric other death row inmate, Donald Moeller, is scheduled to be executed this month. ELISHA PAGE / ARGUS LEADER

ONLINE

WATCH: See video from the cene Monday, a post-execution ews conference, court proceedngs in the case and documents.
CHAT: Watch a replay of a chat Monday with Managing Editor atrick Lalley and reporter John ult about the case.
ARGUSLEADER.COM/
EXECUTION BLOG: See photo alleries, video interviews and nore in a special online section
ARGUSLEADER.COM/
EXECUTIONS

INSIDE

FAMILY: Slain prison guard's family reacts
VIGILS: Death penalty supporters, opponents
MOOD: Reaction in Sioux Falls
TIMELINE: Events leading to the execution
STORIES: Pages 4-5A

Witnessing death final step in sad saga

By John Hult
jhult@argusleader.com

By the time you read this, Eric Robert will be dead, executed by lethal injection for the murder of Corrections Officer Rod Johnson.

Through the window of a tiny exam room, seven other people and I watched Robert heave his last breaths and speak his last words.

Two were deputies for Attorney General Marty Jackley, who watched the death from one of the other three rooms. A reporter from the Associated Press and I joined them, Minnehaha County Jail Warden Darin Young and three other employees of the DOC in the room.

My job as a media witness was to observe, walk back to a briefing room in the Ronald "R.J." Johnson training center and answer questions from other reporters about what happened.

I'd never witnessed an execution until last night, so I called three reporters who had, to gather insight.

The consensus: The death it-

See WITNESS, Page 6A

Breast cancer care gets lift

3.5M from Helmsley trust to benefit treatment in remote areas

By Jon Walker
jwalker@argusleader.com

A research group including era Health received $3.5 mil- Monday for a breast cancer gram that will use genetics personalize treatment for nen.

The grant from the Leona M. Harry B. Helmsley Charita- Trust will support an effort nalyze DNA, compare treat-



Amy Krie

in the Dakotas, Montana, Wyoming and Nebraska.

"This grant will open new doors of opportunity and lead to better care for patients in our region and across the nation," said Dr. Amy Krie, medical oncologist with the Avera Cancer Institute.

the Ramkota Inn in Sioux Falls.

The direct recipient of the money will be the University of Nebraska Medical Center in Omaha. The university's Eppley Cancer Center will work with Avera, the Trinity Health Cancer Center in Minot, N.D., and the Welch Cancer Center at Sheridan Memorial Hospital in Wyoming.

The grant is part of an overall $5.9 million project, with the

EXHIBIT
1

Witness: Family, friends will cope with

Continued from Page 1A

self, so long as nothing goes wrong, essentially is a non-event for the witnesses.

They were right. When Warden Doug Weber asked Associate Warden Troy Ponto to open the white blinds that covered our windows from the inside of the execution chamber, Robert already was strapped down. He had needles in his arms and cloth bandages securing his hands.

He was clean-shaven. His hair was short. His face expressionless.

Warden Doug Weber asked for his last words.

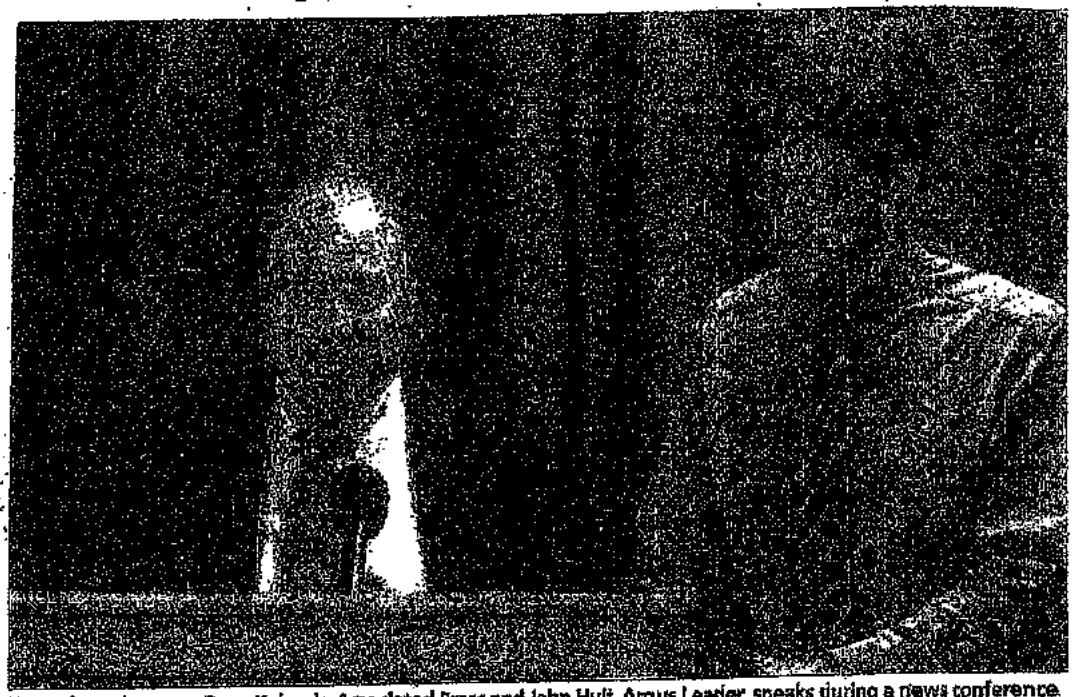
The last three stood out: "It is done," spoken with pauses, as though each word were its own sentence.

He closed his eyes and whispered what sounded like prayers to himself for about a minute. Three minutes after 10 p.m., he heaved three or four heavy sighs and made a sound similar to the clearing of a dry throat.

His eyes suddenly opened, and his chest stopped moving. His eyes remained open as the assistant coroner checked for a pulse at his wrist, chest and neck.

Three minutes. His skin tone had changed by 10:25 p.m., when coroner Kenneth Snell pronounced him dead, but nothing else about Robert changed after 10:03.

When Elijah Page was executed in 2007, the entire process, from his arrival in the execution chamber to the pronouncement of his death, took 31 minutes. He stopped moving six minutes after the drugs were administered after a single, heaving snore. He was pronounced dead at 10:11 p.m.



Execution witnesses, Dave Kolpack, Associated Press and John Hult, Argus Leader, speaks during a news conference following the execution of Eric Robert on Monday at the South Dakota State Penitentiary in Sioux Falls. Robert confe to murdering corrections officer Ronald "R.J." Johnson during an escape attempt in April 2011. ELISHA PAGE/ARGUS LEADER

The minutes before Robert's execution were more troubling than the death. We were guided from the front door through the penitentiary's West Gate. That's the gate where Robert and his accomplice Rodney Berget were captured after killing Johnson.

We walked through the prison yard and into the old infirmary, where we all sat —mostly in silence— in an office filled with photos of Little League games. The leader for our group then took us to the exam room, which still is used to treat patients.

It's ironic that the lives of death row inmates are taken in such a rapid, painless fashion inside what is essentially a working clinic. The media blitz surrounding the death, the years of legal scrutiny, the preparations — all of it leads to a supposedly painless killing that lasts just a matter of minutes.

It's a manner of death reserved only for people executed in the United States.

It stands in stark contrast to the experience of the victims.

The Johnson family's private tragedy has played out in the public to excruciating effect since April 12, 2011, the day Robert and Berget killed Johnson.

I feel, as anyone who's followed the case closely surely does, that I know Johnson on some level.

He was beloved at home and at work and seemed to have no enemies to speak of, despite his 23 years as an authority figure at a high-security prison.

He was working on his 63rd birthday, his day off, covering a shift at someone else's post.

I feel as though I know Robert on some level, as well, having read about and researched his life.

I imagine some people believe journalists enjoy talking to grieving families, following tragedy or witnessing and hearing horrors recalled and recounted.

I've never met a journalist who does.

It's part of the job, which is to keep readers informed of what the government — including the police and courts — is up to.

In practice, for those closest to a crime, we become part of the emotional grinder that victims, criminals and their families are put through after a murder takes place.

Just as they are dra into the justice systen willingly by a crime o other's creation, they dragged into the spot and become public figu

The families ide bodies, spend hours ing with detectives, through trials and ings and sometimes fy, reliving their ex ences. They listen to fense lawyers' que their credibility, down the crimes that hurt then ask judges to their wrongdoers mercy than victims shown.

The families friends of the crim have to live with the ments of the victims' ilies and the public, live with the shame.

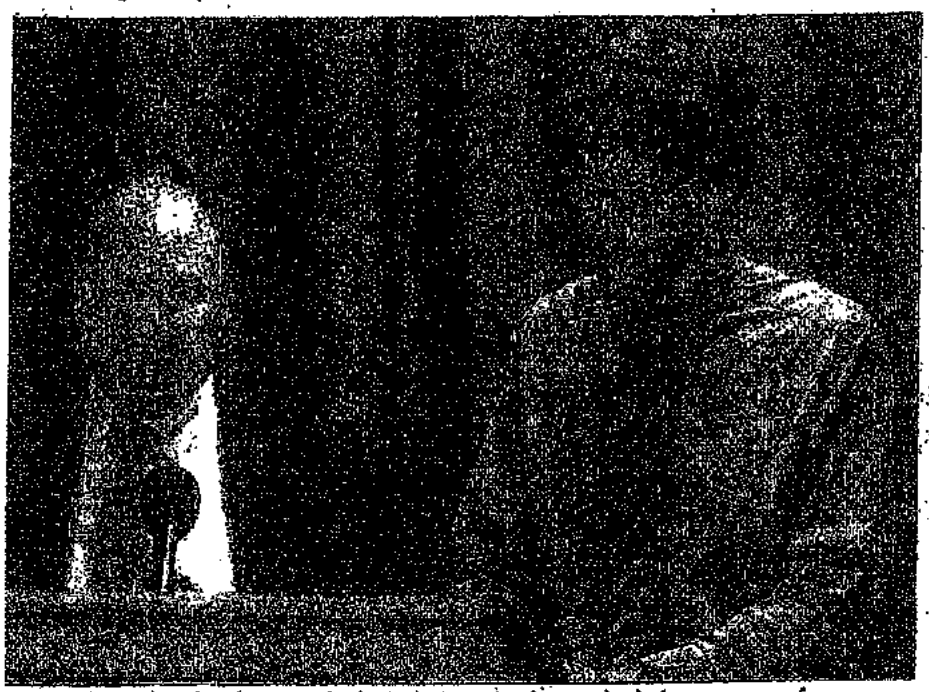
All of those people s risk of getting a call someone like me who

ARGUSLEADER.COM

LOCAL

Tuesday, October 16, 2012

mily, friends will cope with aftermath



Dave Kolpack, Associated Press and John Hult, Argus Leader, speaks during a news conference on of Eric Robert on Monday at the South Dakota State Penitentiary in Sioux Falls. Robert confessed ons officer Ronald "R.J." Johnson during an escape attempt in April 2011. ELISHA PAGE / ARGUS LEADER

ONLINE

John Hult has been the public safety reporter since 2009. Follow his blog on crime and courts at http://jhult.tumblr.com/.

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In practice, for those closest to a crime, we become part of the emotional grinder that victims, criminals and their families are put through after a murder takes place.

Just as they are dragged into the justice system unwillingly by a crime of another's creation, they are dragged into the spotlight and become public figures.

The families identify bodies, spend hours talking with detectives, sit through trials and hearings and sometimes testify, reliving their experiences. They listen to defense lawyers question their credibility, downplay the crimes that hurt them then ask judges to show their wrongdoers more mercy than victims were shown.

The families and friends of the criminals have to live with the judgments of the victims' families and the public, and live with the shame.

All of those people are at risk of getting a call from someone like me who will ask them to repeat and relive those experiences in the name of an informed public.

It's not easy to hear a person cry on the other end of a telephone.

At this point, I've spent weeks thinking about the tears shed by Lynette Johnson and her children, Missy and Jesse, at Robert's sentence hearing.

Will Lynette, who spent only six nights away from her husband in 32 years, feel some measure of closure now?

How will Missy and Jesse, who struggled to explain the loss of "Papa" to their young children, explain what happened Monday?

And what of Robert's family? What of his 72-year-old mother, who worked three jobs in hopes of seeing her children grow into a better life? What was she experiencing as her only son's death approached?

As a crime reporter in a state that puts its worst offenders to death, it was my duty to report the details of the execution. I've been mentally preparing for this.

I realize that emotional separation is a fantasy, but I'm doing my job. So were Attorney General Marty Jackley, Minnehaha County State's Attorney Aaron McGowan, and many of the other witnesses.

Robert's swift, painless end will resonate for the other witnesses far more than it will for us.

The Washington Post

Back to previous page



South Dakota inmate who killed prison guard put to death in state's first execution since 2007

By Associated Press, Published: October 15

SIOUX FALLS, S.D. — A South Dakota man who beat a prison guard with a pipe and covered his head in plastic wrap to kill him during a failed escape attempt was put to death Monday, in the state's first execution since 2007.

Eric Robert, 50, received lethal injection and was pronounced dead at the state penitentiary in Sioux Falls at 10:24 p.m. He is the first South Dakota inmate to die under the state's new single-drug lethal injection method, and only the 17th person to be executed in the state or Dakota Territory since 1877.

Robert had no expression on his face. Asked if he had a last statement, Robert said: "In the name of justice and liberty and mercy, I authorize and forgive Warden Douglas Weber to execute me for the crimes. It is done."

As the drug was administered, the clean-shaven Robert, wearing orange inmate pants with a white blanket wrapped around his upper body, appeared to be clearing his throat and then began gasping heavily. He then snored for about 30 seconds. His eyes remained opened throughout and his skin turned pale, eventually gaining a purplish hue.

Robert was put to death in the same prison where he killed guard Ronald "RJ" Johnson during an escape attempt on April 12, 2011. Robert was serving an 80-year sentence on a kidnapping conviction when he

tried to break out with fellow inmate Rodney Berget, 50.

Johnson's widow, Lynette, said after the execution that she knows Robert's death will not bring back her husband, her children's father or her grandchildren's grandfather.

"But we do know that the employees of the Department of Corrections and the public in general will be just a little bit safer now," Lynette Johnson said. "We need to have more attention and focus on the safety of all of the correctional officers in the state of South Dakota. Ron, none of you will ever know how great he is and is missed. We stand proud for Ron."

Lynette Johnson, her two children and their spouses all witnessed the execution. No one from Robert's family was in attendance.

Robert ate his last meal of ice cream with his lawyer, Mark Kadi, on Saturday night before fasting for 40 hours for religious reasons.

After the execution, Kadi said the execution was very "orderly and polished."

"The problem was it was too orderly. It was so antiseptic and peaceful that it masked what was being done to the person," Kadi said. "If more people were able to see the events, there would be fewer of them."

Johnson was working alone the morning of his death — also his 63rd birthday — in a part of the prison known as Pheasantland Industries, where inmates work on upholstery, signs, custom furniture and other projects. Authorities said the inmates beat Johnson with a pipe, covered his head in plastic wrap and left his body on the floor.

Robert then put on Johnson's pants, hat and jacket and approached the prison's west gate. With his head down, he pushed a cart loaded with two boxes. Berget was hidden in one of the boxes, according to a report filed by a prison worker after the slaying.

Other guards became suspicious as the men got closer to the gate. When confronted, Robert beat one guard; other guards quickly arrived and detained both inmates.

Months later, Robert told a judge his only regret was that he hadn't killed more guards. He pleaded guilty to Johnson's slaying and asked to be sentenced to death, telling a judge last October that he would otherwise kill again. He never appealed his sentence and even tried to bypass a mandatory state review in hopes of expediting his death.

Berget also has pleaded guilty in the killing but has appealed his death sentence. A third inmate, Michael Nordman, 47, was given a life sentence for providing materials used in the slaying.

Robert's execution could be the first of two in as many weeks. Donald Moeller is scheduled to be put to death the week of Oct. 28 for the 1990 kidnapping, rape and murder of a 9-year-old girl. Robert had been on death row only for about a year, Moeller has been there for more than two decades. Only three other inmates currently are on the state's death row.

South Dakota's last execution before Monday took place in 2007, and that was the first in the state for 60 years.

"You have few people on death row, few executions, and then you have this coincidence of cases coming all at once," said Richard Dieter, executive director of the nonprofit Death Penalty Information Center. "When people waive appeals, their cases start to move more quickly."

Associated Press writers Amber Hunt in Sioux Falls and Blake Nicholson in Bismarck contributed to this report.

Follow Kristi Eaton on Twitter at http://twitter.com/kristieaton.

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UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH DAKOTA
SOUTHERN DIVISION

DONALD E. MOELLER,	*	Civ. 04-4200
	*	
Plaintiff,	*	
	*	AFFIDAVIT OF DEPONENT # 1
v.	*	
	*	
DOUGLAS WEBER, Warden, South Dakota State Penitentiary, **DENNIS KAEMINGK,** Secretary of the South Dakota Department of Corrections, and **DOES 1-20,** unknown employees or agents of the South Dakota Department of Corrections,	*	
	*	
Defendants.	*	

State of South Dakota *
* ss.
County of Minnehaha *

I, Deponent # 1, being first duly sworn upon oath, testify on personal knowledge and belief as follows:

1. Deponent # 1 compounded drugs intended for use in Donald Moeller's execution on or about October 3, 2012. The drugs were compounded on this date to allow time for testing prior to Moeller's execution.

2. Deponent # 1 submitted a test sample of the compounded drug to a lab customarily used by my pharmacy. The lab was chosen by me with no influence from the state. On October 17, 2012, the lab reported that the drug I compounded meets USP standards for purity, potency, sterility, and 30-day stability. A redacted report is attached.

Dated this 22nd day of October 2012.

Deponent #1
Deponent # 1

Subscribed and sworn to before me this 22nd day of October 2012.

Maxine J. Risty
Notary Public- South Dakota

(SEAL)
My commission expires: October 15, 2017

MAXINE J. RISTY
NOTARY PUBLIC
SOUTH DAKOTA

[redacted]

Product Release Report
FINAL DATA

Report Date 10/17/2012

Sponsor [redacted]

Sample No. 39521

Product Description **Sodium Pentobarbital 50 mg/ml**
Lot No. 1045082A
Expiry 11/1/2012

Release Specification: SPEC-PSSD-006.0

Procedure	Specification	Final Data	Status	Date of Test	Reference
Pyrogen	NMT 0.8 EU/mL	0.46 EU/mL	Passes	10/4/2012	USP <85>
Sterility	Negative	Negative	Passes	10/3/2012	USP <71>
Fungal Screening	Negative	Negative	Passes	10/3/2012	USP <71>
HPLC	90-110% as Sodium Pentobarbital	106.7% 53.3 mg/mL	Passes	10/4/2012	HPLC-TM-217.0

Date Received: 10/3/2012
Quantity Received: 1 x 40 ml

Carrier: [redacted]
Tracking No.: [redacted]

[redacted]

This report shall not be reproduced except in full, without written approval from [redacted]

X2

STATE OF SOUTH DAKOTA
COUNTY OF PENNINGTON

CHARLES RUSSELL RHINES

Petitioner,

vs.

DOUGLAS WEBER, Warden, South Dakota State Penitentiary,

Respondent.

IN CIRCUIT COURT
SEVENTH JUDICIAL CIRCUIT

CIV. 02-924

AFFIDAVIT OF DOUGLAS WEBER

Affiant, after first being sworn upon his oath, states as follows:

1. If called at trial, affiant would testify to the following facts.
2. I am the Warden of the South Dakota State Penitentiary. In that capacity I carried out the execution of Donald Eugene Moeller on October 30, 2012. Moeller's execution was performed using compounded pentobarbital.
3. I was in the execution chamber standing at Moeller's right shoulder during the entire execution. Once Moeller made his initial last statement, I signaled the executioners in the chemical room to commence the injection.
4. After about 30 seconds, Moeller uttered a final sentence in response to sounds being made by locked-down inmates housed in the same wing of the building where the execution chamber is located. Approximately 15 seconds after this final sentence, Moeller lost consciousness and expelled a faint snore. Moeller remained unconscious until he was pronounced dead by the coroner. Moeller expelled a few last deep breaths approximately 60 seconds after I signaled to commence the injection. Visible indicators of a pulse ceased after approximately 4 minutes. After approximately 23 minutes, Moeller was pronounced dead by the coroner. A copy of the official execution timeline record is attached hereto as Exhibit 1.
5. Moeller exhibited virtually no signs of pain or physical distress during either the seconds he remained conscious after the injection commenced or during the period of unconsciousness before he died. A media witness described the execution as "very quick." The witness "didn't see him [Moeller] in any pain at all." According to the witness, Moeller's execution was, like reports of the Robert execution, "very

EXHIBIT
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14

clinical. Very quick. If this man [Moeller] was in pain, [the witness] didn't see it." Moeller was "gone" in "a matter of [a] minute." Excerpts of the media witness' public statements are attached hereto as Exhibit 2 and are an accurate description of the event.

6. Moeller was executed via the same protocol and with the same drug intended for use in the execution of Charles Russell Rhines. Due to then-pending litigation in Moeller's case, I ordered the drugs for Moeller's execution tested. The pharmacist had the drugs tested by an independent lab. The testing informed me that the compounded pentobarbital used in Moeller's execution had passed authoritative USP standards for purity, potency, and sterility. A copy of the testing report is attached as Exhibit 3.

Dated this 1 day of November 2012.

Douglas Weber

Subscribed to and sworn before me this 1 day of November 2012.

Notary Public

My Commission Expires: 6/16/16 SEAL

PATSY MIKEL
NOTARY PUBLIC
SOUTH DAKOTA

Execution Timeline Record

Inmate name: **Donald Moeller** Inmate number: **# 28137**

Execution Date: 10/30/12

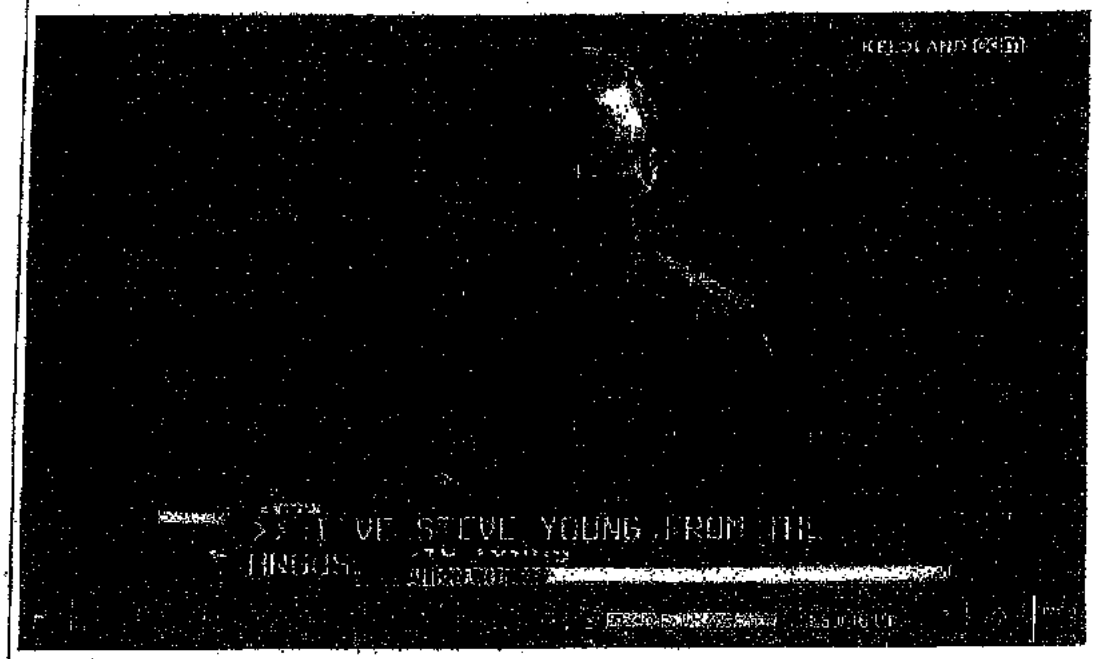
1. Removed from holding cell Time: 9:38 pm
2. Transferred to table Time: 9:39 pm
3. Restraints secured Time: 9:41 pm
4. IV started Time: Right arm 9:43 pm
   Left arm 9:49 pm
   (Note whether arm, leg, or other)
5. Begin escorting witnesses to viewing rooms Time: 9:53 pm
6. All witnesses present. Time: 9:57 pm
7. Warden orders curtains opened. Time: 9:59 pm
8. Secretary of Corrections informs Warden that the Warden is cleared to proceed with the execution. Time: 10:00 pm
9. Last statement Time: 10:01 pm
10. Injections begin Time: 10:01 pm
11. Injections completed Time: 10:04 pm
12. Second set of injections required? ___YES ✓NO
    a. If yes, time second injections were started. Time:_____
    b. Time second injections completed. Time:_____
13. Death pronounced Time: 10:24 pm
14. Curtains closed Time: 10:24 pm

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State Executes Donald Moeller

The Sioux Falls man who just recently admitted killing a 9-year-old girl 22 years ago has been executed at the South Dakota State Penitentiary.

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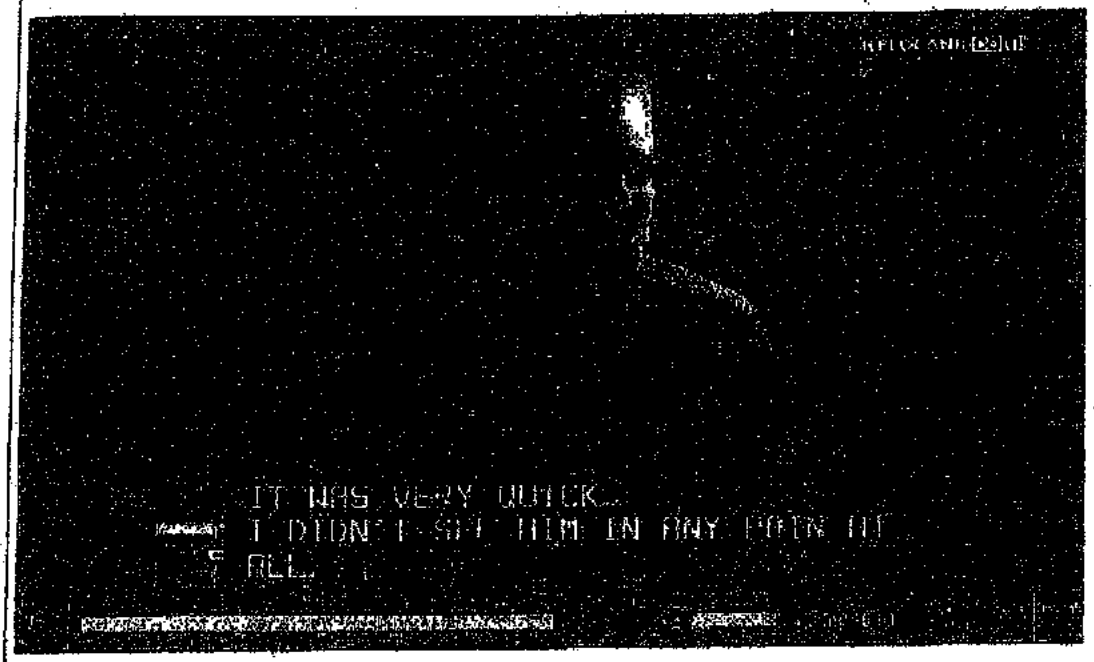
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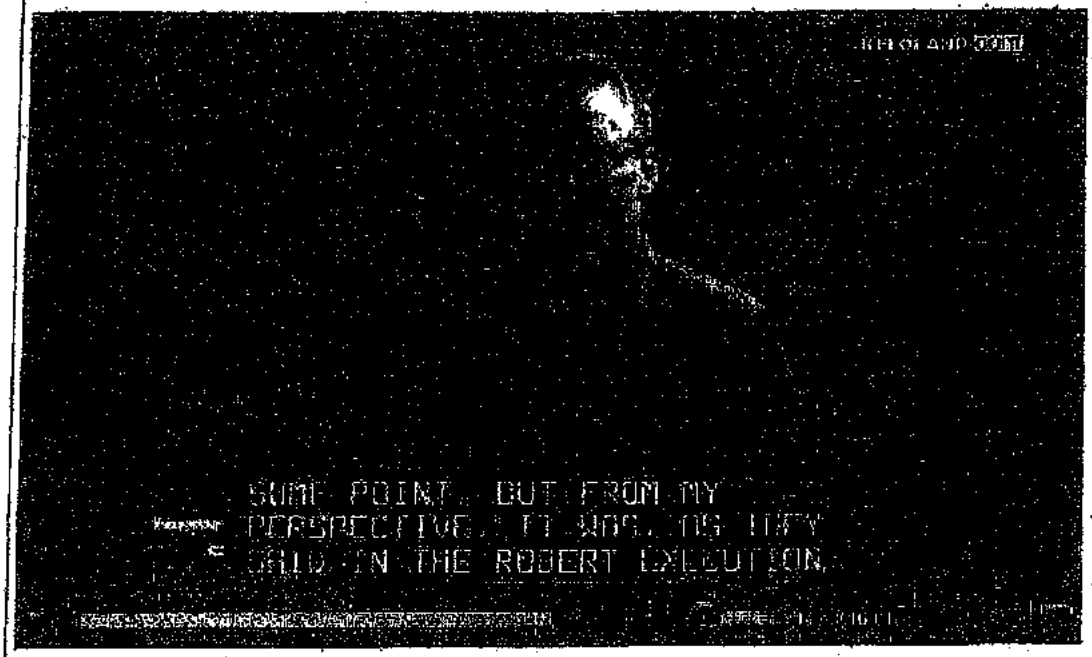
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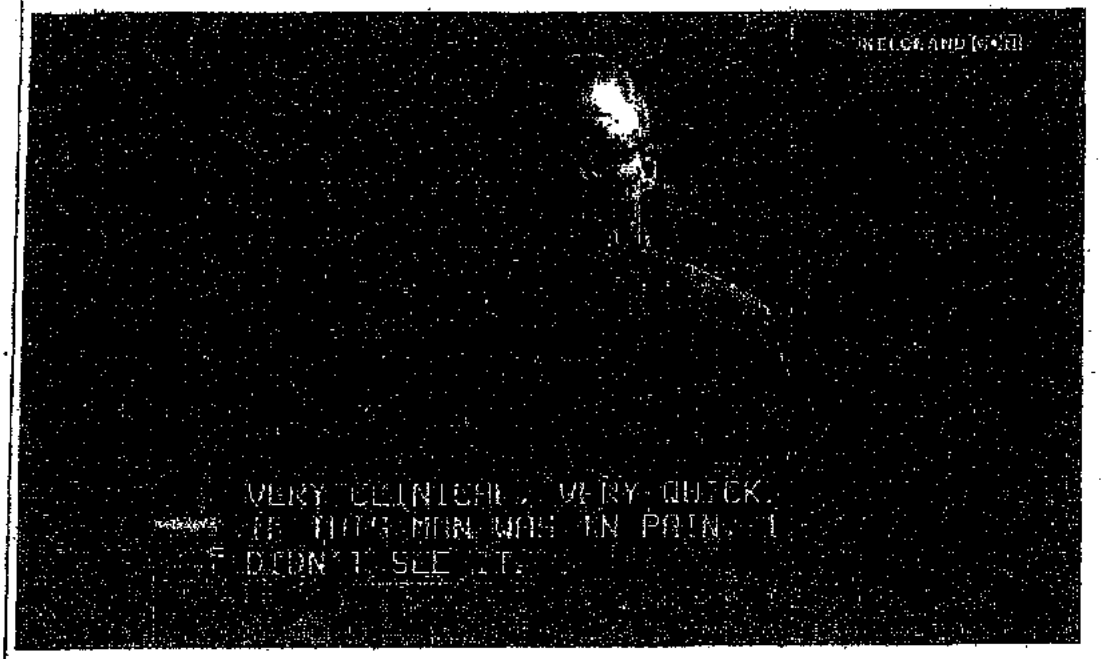
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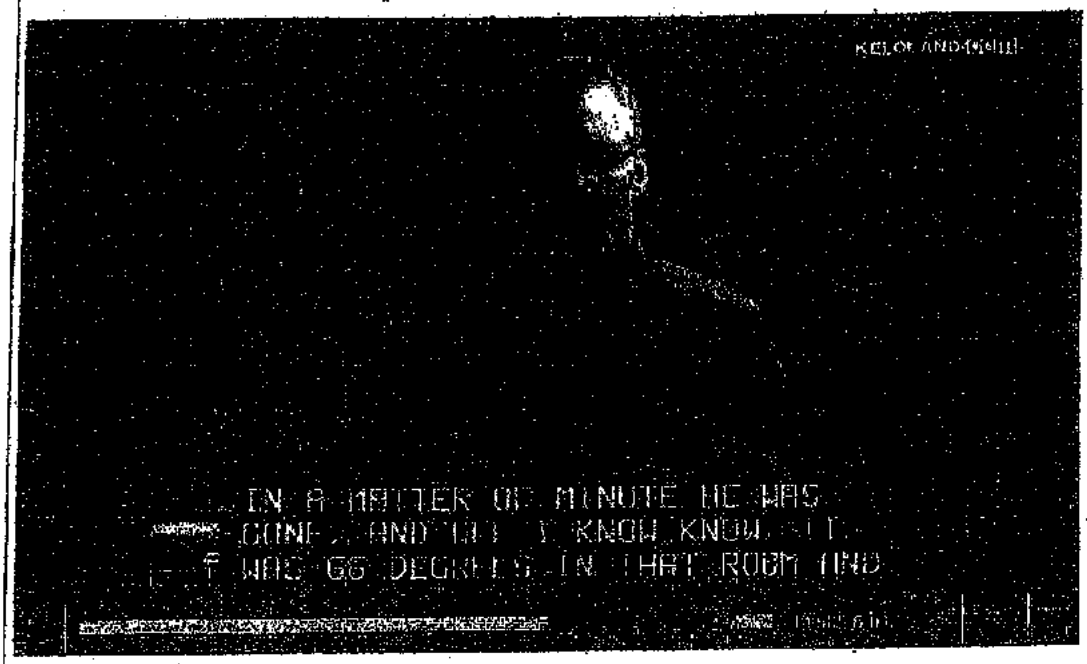
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UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH DAKOTA
SOUTHERN DIVISION

DONALD E. MOELLER,	*	Civ. 04-4200
Plaintiff,	*	
	*	AFFIDAVIT OF DEPONENT # 1
v.	*	
DOUGLAS WEBER, Warden, South Dakota State Penitentiary, **DENNIS KAEMINGK,** Secretary of the South Dakota Department of Corrections, and **DOES 1-20,** unknown employees or agents of the South Dakota Department of Corrections,	*	
Defendants.	*	

State of South Dakota *
* ss.
County of Minnehaha *

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Dated this 22nd day of October 2012.

Deponent #1
Deponent # 1

Subscribed and sworn to before me this 22nd day of October 2012.

Maxine J. Risty
Notary Public- South Dakota

(SEAL)
My commission expires: October 15, 2017

EXHIBIT
3

MAXINE J RISTY
NOTARY PUBLIC
SOUTH DAKOTA

[redacted]

Product Release Report
FINAL DATA

Report Date 10/17/2012

Sponsor [redacted]

Sample No. 39521

Product Description Sodium Pentobarbital 50 mg/ml
Lot No. 1045082A
Expiry 11/1/2012

Release Specification: SPEC-P99D-006.0

Procedure	Specification	Final Data	Status	Date of Test	Reference
Pyrogen	NMT 0.8 EU/mL	0.48 EU/mL	Passes	10/4/2012	USP <85>
Sterility	Negative	Negative	Passes	10/9/2012	USP <71>
Fungal Screening	Negative	Negative	Passes	10/3/2012	USP <71>
HPLC	90-110% as Sodium Pentobarbital	106.7% 53.3 mg/mL	Passes	10/4/2012	HPLC-TM-217.0

Date Received: 10/3/2012
Quantity Received: 1 x 40 ml

Carrier: [redacted]
Tracking No.:

[redacted]

This report shall not be reproduced except in full, without written approval from [redacted]

135 S.Ct. 2726

Supreme Court of the United States
Richard E. GLOSSIP, et al., Petitioners
v.
Kevin J. GROSS, et al.
No. 14–7955.
Argued April 29, 2015.Decided June 29, 2015.

Synopsis

Background: State death-row inmates brought § 1983 action alleging that Oklahoma's three-drug lethal injection protocol created an unacceptable risk of severe pain in violation of Eighth Amendment. The United States District Court for the Western District of Oklahoma, Stephen P. Friot, J., 2014 WL 7671680, entered an order denying inmates' motion for a preliminary injunction, and they appealed. The United States Court of Appeals for the Tenth Circuit, Briscoe, Chief Judge, 776 F.3d 721, affirmed. Certiorari was granted.

Holdings: The Supreme Court, Justice Alito, held that:
1 inmates failed to establish that any risk of harm was substantial when compared to a known and available method of execution, and
2 district court did not commit clear error in finding that midazolam was likely to render an inmate unable to feel pain.
Affirmed.
Justice Scalia filed a concurring opinion in which Justice Thomas joined.
Justice Thomas filed a concurring opinion in which Justice Scalia joined.
Justice Breyer filed a dissenting opinion in which Justice Ginsburg joined.
Justice Sotomayor filed a dissenting opinion in which Justices Ginsburg, Breyer, and Kagan joined.

910 Petitioners attack the District Court's findings of fact on two main grounds.[3] First, they argue that even if midazolam is powerful enough to induce unconsciousness, it is too weak to maintain unconsciousness and insensitivity to pain once the second and third drugs are administered. Second, while conceding that the 500–milligram dose of midazolam is much higher than the normal therapeutic dose, they contend that this fact is irrelevant because midazolam has a "ceiling effect"—that is, at a certain point, an increase in the dose administered will not have any greater effect on the inmate. Neither argument succeeds.

EXHIBIT
tabbies
15

The District Court found that midazolam is capable of placing a person "at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from the application of the second and third drugs." App. 77. This conclusion was not clearly *2741 erroneous. Respondents' expert, Dr. Evans, testified that the proper administration of a 500–milligram dose of midazolam would make it "a virtual certainty" that any individual would be "at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from application of the 2nd and 3rd drugs" used in the Oklahoma protocol. *Id.,* at 302; see also *id.,* at 322. And petitioners' experts acknowledged that they had no contrary scientific proof. See *id.,* at 243–244 (Dr. Sasich stating that the ability of midazolam to render a person insensate to the second and third drugs "has not been subjected to scientific testing"); *id.*, at 176 (Dr. Lubarsky stating that "there is no scientific literature addressing the use of midazolam as a manner to administer lethal injections in humans").

In an effort to explain this dearth of evidence, Dr. Sasich testified that "[i]t's not my responsibility or the [Food and Drug Administration's] responsibility to prove that the drug doesn't work or is not safe." Tr. of Preliminary Injunction Hearing 357 (Tr.). Instead, he stated, "it's the responsibility of the proponent to show that the drug is safe and effective." *Ibid.* Dr. Sasich confused the standard imposed on a drug manufacturer seeking approval of a therapeutic drug with the standard that must be borne by a party challenging a State's lethal injection protocol. When a method of execution is authorized under state law, a party contending that this method violates the Eighth Amendment bears the burden of showing that the method creates an unacceptable risk of pain. Here, petitioners' own experts effectively conceded that they lacked evidence to prove their case beyond dispute.

Petitioners attempt to avoid this deficiency by criticizing respondents' expert. They argue that the District Court should not have credited Dr. Evans' testimony because he admitted that his findings were based on " 'extrapolat [ions]' " from studies done about much lower therapeutic doses of midazolam. See Brief for Petitioners 34 (citing Tr. 667–668; emphasis deleted). But because a 500–milligram dose is never administered for a therapeutic purpose, extrapolation was reasonable. And the conclusions of petitioners' experts were also based on extrapolations and assumptions. For example, Dr. Lubarsky relied on "extrapolation of the ceiling effect data." App. 177.

Based on the evidence that the parties presented to the District Court, we must affirm. Testimony from both sides supports the District Court's conclusion that midazolam can render a person insensate to pain. Dr. Evans testified that although midazolam is not an analgesic, it can nonetheless "render the person unconscious and 'insensate' during the remainder of the procedure." *Id.,* at 294. In his discussion about the ceiling effect, Dr. Sasich

agreed that as the dose of midazolam increases, it is "expected to produce sedation, amnesia, and finally lack of response to stimuli such as pain (unconsciousness)." *Id.,* at 243. Petitioners argue that midazolam is not powerful enough to keep a person insensate to pain after the administration of the second and third drugs, but Dr. Evans presented creditable testimony to the contrary. See, *e.g.,* Tr. 661 (testifying that a 500–milligram dose of midazolam will induce a coma).[4] Indeed, low doses of midazolam ***2742** are sufficient to induce unconsciousness and are even sometimes used as the sole relevant drug in certain medical procedures. Dr. Sasich conceded, for example, that midazolam might be used for medical procedures like colonoscopies and gastroscopies. App. 267–268; see also Brief for Respondents 6–8.[5]

Petitioners emphasize that midazolam is not recommended or approved for use as the sole anesthetic during painful surgery, but there are two reasons why this is not dispositive. First, as the District Court found, the 500–milligram dose at issue here "is many times higher than a normal therapeutic dose of midazolam." App. 76. The effect of a small dose of midazolam has minimal probative value about the effect of a 500–milligram dose. Second, the fact that a low dose of midazolam is not the *best* drug for maintaining unconsciousness during surgery says little about whether a 500–milligram dose of midazolam is *constitutionally adequate* for purposes of conducting an execution. We recognized this point in *Baze,* where we concluded that although the medical standard of care might require the use of a blood pressure cuff and an electrocardiogram during surgeries, this does not mean those procedures are required for an execution to pass Eighth Amendment scrutiny. 553 U.S., at 60, 128 **S.Ct.** 1520.

Oklahoma has also adopted important safeguards to ensure that midazolam is properly administered. The District Court emphasized three requirements in particular: The execution team must secure both a primary and backup IV access site, it must confirm the viability of the IV sites, and it must continuously monitor the offender's level of consciousness. The District Court did not commit clear error in concluding that these safeguards help to minimize any risk that might occur in the event that midazolam does not operate as intended. Indeed, we concluded in *Baze* that many of the safeguards that Oklahoma employs—including the establishment of a primary and backup IV and the presence of personnel to monitor an inmate—help in significantly reducing the risk that an execution protocol will violate the Eighth Amendment. *Id.,* at 55–56, 128 **S.Ct.** 1520. And many other safeguards that Oklahoma has adopted mirror those that the dissent in *Baze* complained were absent from Kentucky's protocol in that case. For example, the dissent argued that because a consciousness check before injection of the second drug "can

reduce a risk of dreadful pain," Kentucky's failure to include that step in its procedure was unconstitutional. *Id.*, at 119, 128 **S.Ct**. 1520 (opinion of GINSBURG, J.). The dissent also complained that Kentucky did not monitor the effectiveness of the first drug or pause between injection of the first and second drugs. *Id.*, at 120–121, 128 **S.Ct**. 1520. Oklahoma has accommodated each of those concerns.

B

Petitioners assert that midazolam's "ceiling effect" undermines the District Court's ***2743** finding about the effectiveness of the huge dose administered in the Oklahoma protocol. Petitioners argue that midazolam has a "ceiling" above which any increase in dosage produces no effect. As a result, they maintain, it is wrong to assume that a 500–milligram dose has a much greater effect than a therapeutic dose of about 5 milligrams. But the mere fact that midazolam has such a ceiling cannot be dispositive. Dr. Sasich testified that "all drugs essentially have a ceiling effect." Tr. 343. The relevant question here is whether midazolam's ceiling effect occurs below the level of a 500–milligram dose and at a point at which the drug does not have the effect of rendering a person insensate to pain caused by the second and third drugs. Petitioners provided little probative evidence on this point, and the speculative evidence that they did present to the District Court does not come close to establishing that its factual findings were clearly erroneous. Dr. Sasich stated in his expert report that the literature "indicates" that midazolam has a ceiling effect, but he conceded that he "was unable to determine the midazolam dose for a ceiling effect on unconsciousness because there is no literature in which such testing has been done." App. 243–244. Dr. Lubarsky's report was similar, *id.*, at 171–172, and the testimony of petitioners' experts at the hearing was no more compelling. Dr. Sasich frankly admitted that he did a "search to try and determine at what dose of midazolam you would get a ceiling effect," but concluded: "I could not find one." Tr. 344. The closest petitioners came was Dr. Lubarsky's suggestion that the ceiling effect occurs "[p]robably after about ... 40 to 50 milligrams," but he added that he had not actually done the relevant calculations, and he admitted: "I can't tell you right now" at what dose the ceiling effect occurs. App. 225. We cannot conclude that the District Court committed clear error in declining to find, based on such speculative evidence, that the ceiling effect negates midazolam's ability to render an inmate insensate to pain caused by the second and third drugs in the protocol.

The principal dissent discusses the ceiling effect at length, but it studiously avoids suggesting that petitioners presented probative evidence about the dose at which the ceiling effect occurs or about whether the effect occurs before a person becomes insensate to pain. The principal dissent avoids these critical issues by suggesting that such evidence is "irrelevant if there is

no dose at which the drug can ... render a person 'insensate to pain.' " *Post,* at 2789. But the District Court heard evidence that the drug can render a person insensate to pain, and not just from Dr. Evans: Dr. Sasich (one of petitioners' own experts) testified that higher doses of midazolam are "expected to produce ... lack of response to stimuli such as pain." App. 243.[6]

In their brief, petitioners attempt to deflect attention from their failure of proof regarding midazolam's ceiling effect by criticizing Dr. Evans' testimony. But it was *petitioners'* burden to establish that midazolam's ceiling occurred at a dosage below the massive 500–milligram dose employed in the Oklahoma protocol and at a point at which the drug failed to render the recipient insensate to pain. They did ***2744** not meet that burden, and their criticisms do not undermine Dr. Evans' central point, which the District Court credited, that a properly administered 500–milligram dose of midazolam will render the recipient unable to feel pain.

One of petitioners' criticisms of Dr. Evans' testimony is little more than a quibble about the wording chosen by Dr. Evans at one point in his oral testimony. Petitioners' expert, Dr. Lubarsky, stated in his report that midazolam "increases effective binding of [gamma-aminobutyric acid (GABA)] to its receptor to induce unconsciousness."[7] App. 172. Dr. Evans' report provided a similar explanation of the way in which midazolam works, see *id.,* at 293–294, and Dr. Lubarsky did not dispute the accuracy of that explanation when he testified at the hearing. Petitioners contend, however, that Dr. Evans erred when he said at the hearing that "[m]idazolam attaches to GABA receptors, *inhibiting GABA.*" *Id.,* at 312 (emphasis added). Petitioners contend that this statement was incorrect because "far from *inhibiting* GABA, midazolam *facilitates its binding* to GABA receptors." Brief for Petitioners 38. In making this argument, petitioners are simply quarrelling with the words that Dr. Evans used during oral testimony in an effort to explain how midazolam works in terms understandable to a layman. Petitioners do not suggest that the discussion of midazolam in Dr. Evans' expert report was inaccurate, and as for Dr. Evans' passing use of the term "inhibiting," Dr. Lubarsky's own expert report states that GABA's "*inhibition* of brain activity is accentuated by midazolam." App. 232 (emphasis added). Dr. Evans' oral use of the word "inhibiting"—particularly in light of his written testimony—does not invalidate the District Court's decision to rely on his testimony.

Petitioners also point to an apparent conflict between Dr. Evans' testimony and a declaration by Dr. Lubarsky (submitted after the District Court ruled) regarding the biological process that produces midazolam's ceiling effect. But even if Dr. Lubarsky's declaration is correct, it is largely beside the point. What matters for present purposes is the dosage at which the ceiling effect kicks in, not the biological process that produces the effect. And Dr. Lubarsky's

declaration does not render the District Court's findings clearly erroneous with respect to that critical issue.

DECLARATION OF JOSEPH F. ANTOGNINI, M.D., M.B.A.

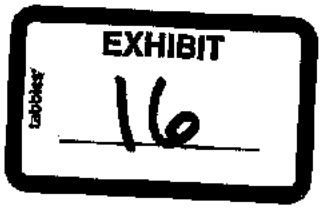
JOSEPH F. ANTOGNINI, does hereby declare and say:

1. My name is Joseph F. Antognini. I am a medical doctor, board-certified in anesthesiology. I received a B.A. degree from the University of California, Berkeley in Economics in 1980. I received my M.D. degree from the University of Southern California in 1984. I also received an M.B.A. from California State University, Sacramento in 2010. I was previously the Director of Peri-operative Services at the University of California, Davis Health System and a Professor of Anesthesiology and Pain Medicine and Professor of Neurobiology, Physiology and Behavior at the University of California, Davis. I am licensed to practice medicine in the State of California. I have over 30 years of experience practicing anesthesiology since 1984 when I began my residency at the University of California, Davis Health System. I am the author or co-author of over 200 publications. My area of research has been focused on anesthetic mechanisms, specifically related to where anesthetics produce unconsciousness, amnesia and immobility. A true and correct copy of my curriculum vitae is attached hereto as Exhibit B.

2. I have reviewed, and am familiar with, the allegations made in the complaint, the reports and/or declarations of Plaintiffs' experts, and additional information in the documents described below.

Scope of Engagement

3. I have been asked to render expert opinions in the fields of general medicine and anesthesiology, especially regarding the use, actions and efficacy of pentobarbital, in relation to South Dakota's lethal injection protocol, and the effectiveness of the procedures therein. I have



also been asked to render opinions regarding the efficacy of pentobarbital in the case of Charles Rhines, a condemned prisoner. This report contains a complete statement of my opinions, and the basis and reasons therefor, including the facts or data I have considered in forming them. The opinions that I do provide are within my field of anesthesiology and such fields as are necessarily related to anesthesiology, including general medicine, pharmacology and physiology, and fall within the scope of my expertise. All opinions expressed herein are stated to a reasonable degree of medical and scientific certainty unless otherwise noted.

Compensation

4. My fee schedule for this matter is as follows: $650 per hour for nontestimonial work; $700 per hour for deposition or video testimony; $6000/day for in-person testimony and travel.

Materials Reviewed

5. I have conferred with attorneys for Defendants. Among the documents I have reviewed in connection with this case are the complaint (49CIV19-002940, filed 10/22/2019), publications in the "References Cited" section and the report of Craig Stevens, PhD. A list of documents I reviewed in preparation of this report is included in Exhibit A.

6. I am advised that discovery is not complete in this case and that more documents and information may become available to me at a later date. Should additional documents or information be provided to me for review and analysis, I reserve the right to take those additional materials into account, and to modify and/or supplement my opinions accordingly. I may also be present at hearings and/or trial. I may take into account any testimony or other evidence to the extent related to my opinions; I may modify and/or supplement my opinions accordingly. In performing my analysis, I have relied on my professional training, education and experience. The opinions presented in this report are my opinions and mine alone. I have reviewed and

considered documents and information and identified those materials (Exhibit A). These documents and other information that I reviewed and considered are of a type reasonably relied upon by experts in the field of anesthesiology, general medicine, physiology and pharmacology in forming opinions or inferences on questions in this area. I have looked upon all of these as valuable sources of information that I am obliged to consider.

Background

7. The intravenous administration of five (5) grams of pentobarbital would result in 1) rapid and deep unconsciousness within 20-30 sec, followed by 2) markedly depressed drive to breathe, followed by 3) absence of breathing, followed by 4) decreased oxygen levels in the body, followed by 5) slowing of the heartbeat, followed by 6) the heart stopping, i.e., death. During this period there will also be cardiovascular depression and collapse.

(see http://emedicine.medscape.com/article/813155-overview#a5 accessed 10-23-19)

8. As stated above, pentobarbital (5 grams) causes rapid unconsciousness followed by respiratory arrest, cardiovascular collapse and death. After intravenous injection of 5 grams pentobarbital, concentrations of pentobarbital will far exceed the lethal concentrations—see Table 1, package insert for pentobarbital in References Cited (Exhibit A) and extrapolating from data of *Ehrnebo* (1974). Once respiratory depression and arrest occurs within 1-2 minutes, the unconscious inmate then begins to use up the oxygen stores in his body, which are estimated to be 1200 ml (*Campbell & Beatty,* 1994). Normal oxygen consumption is about 250-300 ml/min, and virtually all the oxygen in the inmate's body will be used after 4-5 min. In fact, estimates of oxygen saturation after apnea confirm this relationship (*Farmery & Roe,* 1996). Before all the oxygen is used, however, the heart will be affected, will begin to slow and will then have periodic irregular beats. It likely will take several minutes before the heart stops all together. At

that point, death is declared. This process, as described, is irrefutable. It is based on the known actions of pentobarbital and sound pharmacological and physiological principles, and the known effects of these doses of pentobarbital in lethal executions.

9. These actions of pentobarbital are consistent with data published by *Aleman* et al., (2015), a study extensively discussed in the recent US Supreme Court case *Bucklew v. Precythe*, No. 17-8151 (decided April 1, 2019). In the *Aleman* study, horses were administered large, lethal doses of pentobarbital, with a mean time of infusion of 47 seconds, and the horses developed electroencephalographic brain silence (i.e., flat line) at a mean of 53 seconds after the initiation of the infusion, that is, EEG silence occurred on average, 6 seconds after the infusion finished. Because loss of consciousness occurs before EEG silence, these data fit with a time frame of 20-30 seconds for loss of consciousness after the initiation of the pentobarbital infusion.

10. In a similar study (*Buhl* et al., 2013), the time to collapse (when the horses went from standing to falling to the ground) was about 27 seconds (the average of the means of the four groups studied; see their table 2) after the initiation of the infusions. They also noted that respiratory arrest occurred simultaneous with falling to the ground in most horses (2nd paragraph in discussion).

11. These actions of pentobarbital listed above are consistent with the actions of an ultra-fast acting/ultra-short acting barbiturate that is administered in a large lethal dose as specified in the South Dakota protocol.

12. It is important to understand how barbiturate drugs can be classified as "ultra-short acting", "ultra-fast acting", "fast acting" and "short acting", and how this classification is not absolute, and depends in large part on the dose of the drug and the route that it is administered

(oral versus intravenous). The term "short acting" refers to the duration of action, that is, how long (time) does the drug have its intended effect, while "fast acting" refers to the onset of action, how long does it take for an effect to occur. In the case of barbiturates, an "ultra-short acting" barbiturate at a typical clinical dose has a duration of 5-10 minutes, while a "short acting" barbiturate at a typical clinical dose might have a duration of 15 minutes (see Table, Exhibit C). These concepts are outlined graphically in Exhibit D.

13. In the chapter in Miller's Anesthesia (1st Edition, 1981) which contains the material on barbiturates, the author writes:

> "For matters of classification, the barbiturates are divided into four classes according to their duration of activity: long-acting, medium-acting, short-acting, and ultra-short-acting. However, this classification is often altered depending on the route of administration (oral versus intravenous), dose, use of other compounds, and the species." (*Stanley*, 1981).

Because this chapter was written within a few years prior to the 1984 South Dakota law, it informs our understanding of how barbiturates were classified at the time. Clearly, the author conveys the idea that the classification of barbiturates is subject to interpretation and circumstances, specifically dose and route of administration.

14. The inexactitude of this classification has been known for many years and found to be "scientifically unsound" (*Mark*, 1969). In 1969, L.C. Mark described the classification as archaic (*Mark*, 1969) writing:

> "The spectrum of barbiturate effects extends in dose-dependent fashion from sedation to hypnosis to anesthesia to poisoning to death. Any of these

effects can be achieved deliberately or accidentally by any barbiturate given in appropriate dosage…."

15. Likewise, Breimer wrote (*Breimer*, 1979):

"It is surprising that this classification still persists in pharmacology textbooks".

16. In fact, Dr. Stevens, in his chapter on CNS active drugs (*Brenner and Stevens*, Pharmacology, 2018) makes no mention of ultra-short-acting barbiturates, and lumps pentobarbital and thiopental together as "short acting" (see his Table 19-1, pg 209). He distinguishes thiopental's onset of action from pentobarbital's onset as "very fast" versus "fast" but specifies that the onset for thiopental is for the intravenous administration, while for pentobarbital he describes attributes related to oral administration. Thus, even Dr. Stevens's description indicates that these differences are open to interpretation depending on the drug and mode of administration.

17. The administered dose of these drugs, relative to the classification, is important to point out. If a small enough dose of pentobarbital is administered, no effect is observed. If incrementally larger doses are administered, eventually an effect would be seen, but its duration could be on the order of just a few minutes, and thus the drug would be "ultra-short acting". For example, in the *Ehrnebo* study (1974) only 3 of 7 subjects administered 100 mg pentobarbital intravenously fell into a light sleep, and that was for 20-30 min. Thus, a smaller dose in those subjects would have likely produced a shorter duration of action, while a slightly larger dose in the other four subjects would have likely produced an effect with a duration of action in the range of 5-10 minutes (see Exhibit D for graphical representation of this concept).

18. With thiopental administered at large sub-lethal doses for a prolonged period, the duration of action would likely be on the order of hours and would clearly exceed the "ultra-short acting" range. Finally, if thiopental is administered in large lethal doses, as in the setting of an execution, clearly its classification as an "ultra-short acting" barbiturate is meaningless.

19. The decision in the Montana case (*Smith v Montana State Dept of Corrections*, 2015 WL) as cited in the complaint, also uses the terms "ultrafast acting" and "ultrashort acting", and groups the two together (see table at *3), and likewise does the same with "fast acting" and "short acting". Furthermore, the Montana decision describes the opinion of Dr. Heath as follows: "it is often important to have a very quick transition from consciousness to unconsciousness" and that "this is the purpose of the development of ultra-fast-acting barbiturates." (at *2 of the decision).

20. To reiterate, these distinctions mentioned above help inform our understanding of the term "ultra-short acting" in the context of lethal execution. Thiopental and methohexital, which the inmate claims are "ultra-short acting", would not be so at the doses and route administered for lethal injection. At much larger doses, thiopental is not ultra-short acting. Patients administered large doses of thiopental for prolonged periods do not awaken quickly. Furthermore, as noted above, pentobarbital at the dose administered in the South Dakota protocol (5 grams) would induce rapid unconsciousness, within 20-30 seconds.

Conclusion

21. It is my opinion, to a reasonable degree of medical and scientific certainty, that 1) the inmate would become unconscious within 20-30 sec after the initiation of the infusion of the pentobarbital, followed by respiratory arrest, cardiovascular collapse and death; 2) injection of

massive doses of barbiturates in this inmate would not inflict mild, moderate or severe pain; 3) these actions of pentobarbital are consistent with a drug classified as an ultra-fast acting/ultra-short acting barbiturate when administered in these massive doses.

22. Should additional information become available I reserve the opportunity to amend my statements herein.

Date: October 26, 2019



Joseph F. Antognini, M.D., M.B.A.

Exhibit A—References Cited

Aleman M, Williams DC, Guedes A, Madigan JE. Cerebral and brainstem electrophysiologic activity during euthanasia with pentobarbital sodium in horses. J Vet Int Med 2015; 29:663-72

Brenner GM, Stevens CW. Sedative-hypnotic and anxiolytic drugs. In: Pharmacology, 5th Ed. 2018 Elsevier

Breimer DD. Clinical pharmacokinetics and biopharmaceutical aspects of hypnotic drug therapy. In: Sleep Research, Eds. Priest RG, Pletscher A, Ward J. MTP Press, Lancaster, England, 1979

Buhl R, Andersen LOF, Karlshoj M, Kanters JK. Evaluation of clinical and electrocardiographic changes during the euthanasia of horses. The Veterinary Journal 2013; 196:483-91

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Ehrnebo M. Pharmacokinetics and distribution properties of pentobarbital in humans following oral and intravenous administration. J Pharmaceutical Sciences 1975; 63:1114-18

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Mark LC. Archaic classification of barbiturates. Clin Pharmacology Therapeutics 1969; 10:287-291

Stanley TH. Pharmacology of intravenous non-narcotic anesthetics. p452 In: Anesthesia. Ed: Miller RD. Churchill Livingstone, New York, 1981

Wyant GM, Dobkin AB, Aasheim GM. Comparison of seven intravenous anaesthetic agents in man. Brit J Anaesthesia 1957; 29:194-209

Smith v Montana State Dept of Corrections, 2015 WL

Pentobarbital package insert (accessed 10-24-19): http://www.akorn.com/documents/catalog/package_inserts/76478-501-20.pdf

Declaration of Craig Stevens, Ph.D, dated Oct 22, 2019

Complaint 49CIV19-002940, filed 10/22/2019

Pentobarbital data from US National Library of Medicine TOXNET (accessed 10-26-19):

https://toxnet.nlm.nih.gov/cgi-bin/sis/search2/r?dbs+hsdb:@term+@rn+@rel+76-74-4

Thiopental data from US National Library of Medicine TOXNET (accessed 10-26-19):

https://toxnet.nlm.nih.gov/cgi-bin/sis/search2/f?./temp/~DaPJwj:1

Exhibit B

CURRICULUM VITAE
Joseph F. Antognini, M.D., M.B.A.

CONTACT:

jfantognini@icloud.com
jfantognini@ucdavis.edu

EDUCATION:

1980	University of California, Berkeley (B.A., Economics)
1984	University of Southern California (M.D., Medicine)
2010	California State University, Sacramento (M.B.A., Business)

INTERNSHIP/RESIDENCY:

1984-1987	Anesthesiology, UC Davis Medical Center
1986-1987	Chief Resident

PROFESSIONAL POSITIONS:

9/16-present	Physician Surveyor The Joint Commission Oakbrook Terrace, IL
7/17-present	Director Emeritus University of California, Davis
7/11-present	Clinical Professor of Anesthesiology and Pain Medicine (Volunteer Clincal Faculty appointment) University of California, Davis—School of Medicine
11/10-6/16	Director of Peri-operative Services UC Davis Health System
7/00-7/11	Professor of Anesthesiology and Pain Medicine (with tenure) Department of Anesthesiology and Pain Medicine University of California, Davis—School of Medicine
12/02-7/11	Professor of Neurobiology, Physiology and Behavior (with tenure; WOS appointment) College of Biological Sciences University of California, Davis

11/98-7/10	Vice Chairman, Director of Research
11/98-3/02	Director of Malignant Hyperthermia Diagnostic Laboratory Department of Anesthesiology
7/96-7/00	Associate Professor (with tenure) Department of Anesthesiology University of California, Davis—School of Medicine
10/91-6/96	Assistant Professor Department of Anesthesiology University of California, Davis—School of Medicine
7/87-9/91	Staff Anesthesiologist (Private Practice) American River Hospital Department of Anesthesiology Carmichael, CA
7/87-9/91	Assistant Clinical Professor (volunteer) Department of Anesthesiology University of California, Davis—School of Medicine

LICENSURE & CERTIFICATIONS:
State of California #G55662 (active)
Diplomate, National Board of Medical Examiners (1985)
Diplomate, American Board of Anesthesiology (1989)
Certificate of Recertification, American Board of Anesthesiology (1999, 2009)
Certified Yellow Belt, 2017

PROFESSIONAL SOCIETIES AND RECOGNITION:
American Society of Anesthesiologists 1987--present
California Society of Anesthesiologists 1987—present
Fellow of the American Society of Anesthesiologists 2018—present

ADVOCACY
ASA Grassroots Network (ASA Team 535) 2018
ASAPAC Donor—2018
FAER Donor—1999-2018

RESEARCH INTERESTS:
Mechanisms of anesthesia; factors influencing anesthetic requirements; OR efficiency

AWARDS AND HONORS
Dean's Mentoring Award, UC Davis School of Medicine, 2006

Associated Students of UC Davis "Excellence in Education Award" College of Biological Sciences, 2007
Associated Students of UC Davis "Excellence in Education Award" Outstanding Educator, 2007
Foundation for Anesthesia Education and Research, Mentor Academy, 2008
Phi Kappa Phi Honor Society, 2010

GRANTS

1. UC Davis Faculty Research Grant 1991-92—The effect of intrathecal aspirin on anesthetic requirements in rabbits, $2500
2. UC Davis Faculty Research Grant 1993-94—Validation of a preferentially anesthetized goat brain model, $1500
3. Foundation for Anesthesia Education and Research 1994—Determination of gross anatomic sites of anesthetic action, $25,000 ($25,000 matching departmental funds)
4. UC Davis Faculty Research Grant 1994-95—The effects of general anesthesia on cerebral blood flow patterns as assessed by functional magnetic resonance imaging, $1500
5. UC Davis Faculty Research Grant 1996-97—The effect of differential isoflurane delivery to brain and spinal cord on inhibitory and excitatory output from the brain, $10,000
6. Foundation for Anesthesia Education and Research 1997-99—The effect of differential isoflurane delivery to brain and spinal cord on inhibitory and excitatory output from the brain, $70,000 ($70,000 matching departmental funds)
7. NIH R01 GM57970 Brain and Spinal Cord Contributions to Anesthetic Action 8/98-4/02 (Priority Score 120, Percentile 1.0). Total costs $713,026
8. NIH R01 GM61283 Anesthetic Effects on Sensorimotor Integration 2/01-2/06 (Priority Score 194, Percentile 16.9). Total costs $672,791
9. U.C. Davis Faculty Research Grant. Indirect effect of isoflurane and lidocaine on EEG activation. 7/1/01-6/30/02, $4,000
10. NIH R01 GM57970-4A1 Brain and Spinal Cord Contributions to Anesthetic Action 4/02-12/05 (Priority Score 197, Percentile 20). Total costs $1,284,689
11. NIH 3R01GM057970-05S1 Brain and Spinal Cord Contributions to Anesthetic Action. Minority Supplement grant. 7/03-7/04. Total costs $55,932
12. NIH P01 GM47818 Anesthetic Effects on Spinal Nociceptive Processing 8/04-7/09 (Priority Score 185). Total costs $804,325
13. NIH R01 GM61283A1 Anesthetic Effects on Sensorimotor Integration 12/05-12/9 (Priority Score 158, Percentile 9). Total costs $748,432

TEACHING

Post-Graduate:

1. Resident lectures on neuroanesthesia, anesthetic mechanisms, malignant hyperthermia, neuromuscular blocking drugs, volatile anesthetics, anesthesia research. 1991-2019
2. Anesthesiology Department Journal Club 2013-2016

3. UCSF Changing Practice of Anesthesia—Faculty. September 2014: Perioperative Medicine and Healthcare Reform: Challenges and Opportunities for Anesthesiology

Graduate:

Guest lecturer for NPB 219 (E. Carstens, Instructor). 1998-2003
Guest lecturer for NPB 112 (E. Carstens, Instructor). 2001-2008
Guest lecturer for first year medical students—pain physiology 2002-2003
Facilitator, Application of Medical Principles 2002-2008
Guest Lecturer, 210B (Systemic Physiology) January 2006
Instructor of Record, Applied Physiology and Pharmacology 2007, 2008

Undergraduate:

NPB 10—Elementary Human Physiology (4 units). 2001-2009
Freshman Seminar: The Supreme Court and You. (2 units) 1998-2010

MENTORED STUDENTS, RESIDENTS AND POST-DOCTORAL SCHOLARS

1. Kevin Schwartz, M.D.	Resident	1993
2. Michael Borges, M.D	Resident	1994
3. Agi Melton, M.D.	Resident	1994
4. Etsuo Tabo, M.D.	Post-Doctoral Scholar	1997
5. Steven Jinks	Graduate Student	1998-2001
6. Chris Simons	Graduate Student	1998
7. Xiao Wei Wang, M.D.	Post-Doctoral Scholar	1999
8. Xiaoguang Chen, M.D.	Post-Doctoral Scholar	2000
9. Makoto Sudo, M.D.	Post-Doctoral Scholar	2000
10. Satoko Sudo, M.D.	Post-Doctoral Scholar	2000
11. Alison Fitzgerald	Undergraduate Student	2000-2001
12. Andrew Hall	Undergraduate Student	2001
13. John Martin, M.D.	Resident	2001
14. Steve Jinks, PhD.	Post-Doctoral Scholar	2001-2004
15. Jason Cuellar, BS	Graduate Student	2003-2004
16. Linda Barter, MsVM	Graduate Student	2004-2007
17. Mashawn Orth	Graduate Student	2004-2005
18. Carmen Dominguez, MD	Assistant Professor	2003-2005
19. Lauire Mark	Undergraduate Student	2005, 2006
20. Matthew LeDuc	Medical Student	2005
21. Toshi Mitsuyo, M.D.	Post-Doctoral Scholar	2004-2005
22. Kevin Ng, M.D.	Resident	2005-2006
23. JongBun Kim, M.D.	Post-Doctoral Scholar	2006
24. Sean Shargh	Undergraduate Student	2006-2007
25. Aubrey Yao, M.D.	Resident	2006-2007
26. Alana Sulger	Undergraduate Student	2006-2007
27. Gudrun Kungys, M.D.	Resident	2007-2008
28. Jason Talavera	Medical student	2007
29. Onkar Judge	Medical student	2008

30. Andrew Cunningham	Undergraduate Student	2008
31. Lauren Boudewyn	Undergraduate Student	2008
32. Austin Kim	Undergraduate Student	2008
33. Jason Andrada	Graduate Student	2009-2010
34. Jun Ye	Graduate Student	2014-2015
35. Reihaneh Forghany	Resident	2018-2019

SPECIAL ACTIVITIES:

Staff Anesthesiologist, American River Hospital, 1991-1992
Medical Advisor, CMT International (Charcot-Marie-Tooth), 1991-2000
Director, Case Conferences, Department of Anesthesiology, April-June, 1992
Proctor, Medical Board of California, 1992
Staff Membership, Sutter Davis Hospital, Davis, CA, 1992-1995
Consultant, Malignant Hyperthermia Hotline, Malignant Hyperthermia Association of the United States (MHAUS), 1992-2002
Associate, UC Davis Diagnostic Malignant Hyperthermia Laboratory, 1992-2010
Member, Subcommittee on Experimental Neuroscience and Biochemistry, American Society of Anesthesiologists, 1996
Finance and Executive Committees, U.C. Davis Department of Anesthesiology, 1996-2002
Quality Assurance Committee, U.C. Davis Department of Anesthesiology, 1998-2004
Course Director, Annual U.C. Davis Anesthesiology Update (CME meeting), 1996-2003
California Society of Anesthesiologists: Educational Programs Committee, 1998-2000
Coordinator, Grand Rounds, Department of Anesthesiology, 1996
Professional Billing Workgroup, U.C. Davis, 1996-98
Question Writer, American Board of Anesthesiology, 1998-2001
Member, UC Davis Animal Care Committee, 2000-2003
Member, UC Davis School of Medicine Personnel Committee, 2003—2007; Chair 2007
Management Advisory Committee, Department of Anesthesiology, 2007
Ad Hoc Reviewer for *Anesthesiology, Hospital Topics, Journal of Clinical Anesthesia, Journal of Comparative Neurology, Regional Anesthesia and Pain Medicine, Pain, Brain Research, Journal of Neuroscience, Anesthesia and Analgesia, British Journal of Anaesthesia, Neuroscience, Cephalgia, Neuroscience Letters, Jounral of Chromatography, Basic & Clinical Pharmacology & Toxicology, Therapeutics and Clinical Risk Management.*
Member, VA Merit Review Subcommittee, Alcohol and Drug Dependence, 2002-2005
Editor, American Board of Anesthesiology/ American Society of Anesthesiologists In-Training Examination 2003-2008
Associate Editor, *Anesthesiology* 2005—2011
Faculty Execuitve Committee, School of Medicine 2009-2010
Chair, Faculty Execuitve Committee, School of Medicine 2010-2011
Member of various hospital committees 2011-2016: Medical Staff Executive Committee, Quality Safety Committee, OR Committee, Surgical Services Steering Committee

BIBLIOGRAPHY

EDITED BOOKS

1. Antognini JF, Carstens EE, Raines DE. Neural Mechanisms of Anesthesia, Humana Press, Totowa, NJ, 2002.

PUBLICATIONS

1. Antognini JF. Anaesthesia for Charcot-Marie-Tooth disease: a review of 86 cases. Canadian Journal of Anaesthesia 1992; 39(4):398-400.

2. Antognini JF and ND Kien. Cardiopulmonary bypass does not alter canine enflurane requirements. Anesthesiology 1992; 76:953-957.

3. Antognini JF. Intrathecal acetylsalicylic acid and indomethacin are not analgesic for a supramaximal stimulus. Anesthesia and Analgesia 1993; 76:1079-1082.

4. Antognini JF. Hypothermia eliminates isoflurane requirements at 20°C. Anesthesiology 1993; 78:1152-1156.

5. Antognini JF and GA Gronert. Succinylcholine causes profound hyperkalemia in hemorrhagic, acidotic rabbits. Anesthesia and Analgesia 1993; 77:585-588.

6. Melton AT, JF Antognini and GA Gronert. Prolonged duration of succinylcholine in patients receiving anticonvulsants: evidence for mild up-regulation of acetylcholine receptors? Canadian Journal of Anaesthesia 1993; 40(10):939-942.

7. Antognini JF and K Schwartz. Exaggerated anesthetic requirements in the preferentially anesthetized brain. Anesthesiology 1993; 79:1244-1249.

8. Antognini JF and PH Eisele. Anesthetic potency and cardiopulmonary effects of enflurane, halothane, and isoflurane in goats. Laboratory Animal Science 1993; 43(6):607-610.

9. Antognini JF. Splanchnic release of potassium after hemorrhage and succinylcholine in rabbits. Anesthesia and Analgesia 1994; 78:687-690.

10. Antognini JF, M Anderson, M Cronan, JP McGahan and GA Gronert. Ultrasonography: not useful in detecting susceptibility to malignant hyperthermia. Journal of Ultrasound in Medicine 1994; 13:371-374.

11. Antognini JF and ND Kien. A method for preferential delivery of volatile anesthetics to the *in situ* goat brain. Anesthesiology 1994; 80:1148-1154.

12. Antognini JF, BK Lewis and JA Reitan. Hypothermia minimally decreases nitrous oxide anesthetic requirements. Anesthesia and Analgesia 1994; 79:980-982.

13. Borges M and JF Antognini. Does the brain influence somatic responses to noxious stimuli during isoflurane anesthesia? Anesthesiology 1994; 81:1511-1515.

14. Antognini JF and ND Kien. Potency (minimum alveolar anesthetic concentration) of isoflurane is independent of peripheral anesthetic effects. Anesthesia and Analgesia 1995; 81:69-72.

15. Antognini JF and K Berg. Cardiovascular responses to noxious stimuli during isoflurane anesthesia are minimally affected by anesthetic action in the brain. Anesthesia and Analgesia 1995; 81:843-848.

16. Antognini JF. Creatine kinase alterations after acute malignant hyperthermia episodes and common surgical procedures. Anesthesia and Analgesia 1995; 81:1039-1042.

17. Gronert GA, NW Fleming and JF Antognini. Aberrant responses to muscle relaxants produced by diseases or drugs. Seminars in Anesthesia 1995; 14(4):283-290.

18. Hwang F, K Chun, JF Antognini and GA Gronert. Caffeine-halothane accuracy in MH testing. Acta Anaesthesiologica Scandinavica 1995; 39:1036-1040.

19. Antognini JF and K Mark. Hyperkalaemia associated with haemorrhagic shock in rabbits: modification by succinylcholine, vecuronium and blood transfusion. Acta Anaesthesiologica Scandinavica 1995; 39:1125-1127.

20. Antognini JF, R Wood and GA Gronert. Metocurine pharmacokinetics and pharmacodynamics in goats. Journal of Veterinary Pharmacology and Therapeutics 1995; 18:464-467.

21. Antognini JF. Movement associated with high cerebral concentrations of isoflurane: no evidence of seizure activity. Canadian Journal of Anaesthesia 1996; 43(3):310-314.

22. Antognini JF and GA Gronert. Extra-junctional receptors and neuromuscular blocking drugs. Current Opinion in Anaesthesiology 1996; 9:344-347.

23. Kien ND, JF Antognini, DA Reilly and PG Moore. Small-volume resuscitation using hypertonic saline improves organ perfusion in burned rats. Anesthesia and Analgesia 1996; 83:782-788.

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25. Antognini JF, PH Eisele and GA Gronert. Evaluation for malignant hyperthermia susceptibility in black-tailed deer. Journal of Wildlife Diseases 1996; 32(4): 678-681.

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28. Antognini JF and GA Gronert. Effect of temperature variation (22°C-44°C) on halothane and caffeine contracture testing in normal humans. Acta Anaesthesiologica Scandinavica 1997; 41: 639-642.

29. Antognini JF, MH Buonocore, EA Disbrow and E Carstens. Isoflurane anesthesia blunts cerebral responses to noxious and innocuous stimuli: a fMRI study. Life Sciences 1997; 61:PL349-354.

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32. Antognini JF, E Carstens, E Tabo and V Buzin. Effect of differential delivery of isoflurane to head and torso on lumbar dorsal horn activity. Anesthesiology 1998; 88:1055-61

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35. Antognini JF, E. Carstens. Macroscopic sites of anesthetic action: brain versus spinal cord. Toxicology Letters 1998; 100-101:51-58.

36 Antognini JF, E Carstens. Increasing isoflurane from 0.9 to 1.1 minimum alveolar concentration minimally affects dorsal horn cell responses to noxious stimulation. Anesthesiology 1999; 90:208-14.

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42. Antognini JF, E Carstens. Isoflurane blunts electroencephalographic and thalamic/reticular formation responses to noxious stimulation in goats. Anesthesiology 1999; 91:1770-9

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monitored using the bispectral index of the electroencephalogram. Veterinary Research Communications 2000; 24:361-370

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62. Jinks SL, Antognini JF, Carstens E. Spectral analysis of movement patterns during anesthesia.Anesth Analg. 2004; 98:698-702.

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68. Cuellar JC, Antognini JF, Eger EI, Carstens E. Halothane depresses C-fiber-evoked windup of deep dorsal horn neurons in mice. Neurosci Letters 2004; 363:207-11

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80. Carstens E, Antognini JF. Anesthetic effects on the thalamus, reticular formation and related systems. Thalamus and Related Systems. 2005

81. Antognini JF, Barter L, Carstens E. Overview movement as an index of anesthetic depth in humans and experimental animals. Comp Med, 2005; 55(5): 413-8.

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83. LeDuc ML, Atherley RJ, Jinks SL, Antognini JF. Nitrous oxide depresses electroencephalographic responses to repetitive noxious stimulation in the rat. Brit J Anaesth 2006; 96:216-21.

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85. Mitsuyo T, Antognini JF, Carstens E. Etomidate depresses lumbar dorsal horn neuronal responses to noxious thermal stimulation in rats. Anesth Analg. 2006; 102:1169-73.

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87. Hemmings HC, Jr, , Antognini JF. Do general anesthetics add up? Anesthesiology. 2006; 104:1120-2.

88. Merrill AW, Barter LS, Rudolph U, Eger EI 2nd, Antognini JF Carstens MI, Carstens E,. Propofol's effects on nociceptive behavior and spinal c-fos expression after intraplantar formalin injection in mice with a mutation in the gamma-aminobutyric acid-type(A) receptor beta3 subunit. Anesth Analg. 2006; 103:478-83

89. Antognini JF, Atherley RJ, Laster MJ, Carstens E, Dutton RC, Eger EI. A method for recording single unit activity in lumbar spinal cord in rats anesthetized with nitrous oxide in a hyperbaric chamber. J Neurosci Methods, 2006; 160(2): 215-22.

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92. Mitsuyo T, Dutton RC, Antognini JF, Carstens E. The differential effects of halothane and isoflurane on windup of dorsal horn neurons selected in unanesthetized decerebrated rats. Anesth Analg, 2006, 103(3): 753-60.

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96. Antognini JF, Raines DE, Solt K, Barter LS, Atherley RJ, Bravo E, Laster MJ, Jankowska K, Eger EI. Hexafluorobenzene acts in the spinal cord, whereas o-difluorobenzene acts in both brain and spinal cord, to produce immobility. Anesth Analg, 2007; 104(4): 822-8.

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98. Jinks SL, Carstens EE, Antognini JF. Glutamate receptor blockade in the rostral ventromedial medulla reduces the force of multisegmental motor responses to supramaximal noxious stimuli. Neurosci Lett, 2007; 426(3): 175-80.

99. Dutton RC, Cuellar JM, Eger EI, Antognini JF, Carstens E. Temporal and spatial determinants of sacral dorsal horn neuronal windup in relation to isoflurane-induced immobility. Anesth Analg, 2007; 105(6): 1665-74.

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101. Barter LS, Mark LO, Jinks SL, Carstens EE, Antognini JF. Immobilizing doses of halothane, isoflurane or propofol, do not preferentially depress noxious heat-evoked responses of rat lumbar dorsal horn neurons with ascending projections. Anesth Analg, 2008; 106(3): 985-90, table of contents.

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103. Yao A, Kim J, Atherley R, Jinks SL, Carstens E, Shargh S, Sulger A, Antognini JF. The effects of aromatic anesthetics on dorsal horn neuronal responses to noxious stimulation. Anesth Analg, 2008; 106(6): 1759-64.

104. Shnayderman D, Laster MJ, Eger EI 2nd, Oh I, Jinks SL, Antognini JF, Raines DE. Increases in spinal cerebrospinal fluid potassium concentration do not increase isoflurane minimum alveolar concentration in rats. Anesth Analg, 2008; 107(3): 879-84.

105. Talavera JA, Esser SK, Amzica F, Hill S, Antognini JF. Modeling the GABAergic action of etomidate on the thalamocortical system. Anesth Analg, 2009; 108: 160-67.

106. Barter LS, Mark LO, Antognini JF. Proprioceptive function is more sensitive than motor function to desflurane anesthesia. Anesth Analg, 2009; 108: 867-72.

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EXHIBIT C

Table showing typical onset times and durations of action for thiopental (intravenous) and pentobarbital (oral and intravenous)

	TYPICAL ONSET (Clinical dose)	TYPICAL DURATION (Clinical dose)	TYPICAL ONSET (Execution dose)	TYPICAL DURATION (Execution dose)
Thiopental (intravenous)	10-40 seconds*	5-8 minutes* 5-95 minutes, mean 30 minutes**	10-40 seconds	Beyond duration of execution
Pentobarbital (oral pill)	15-60 minutes#	1-4 hours#	NA	NA
Pentobarbital (intravenous)	1 minute#	15 minutes#	20-30 seconds##	Beyond duration of execution

#Pentobarbital data from US National Library of Medicine TOXNET (accessed 10-26-19):

https://toxnet.nlm.nih.gov/cgi-bin/sis/search2/r?dbs+hsdb:@term+@rn+@rel+76-74-4

*Thiopental data from US National Library of Medicine TOXNET (accessed 10-26-19):

https://toxnet.nlm.nih.gov/cgi-bin/sis/search2/f?./temp/~DaPJwi:1

based on *Aleman* et al. (2015) and *Buhl* et al. (2013)

** Wyant GM, Dobkin AB, Aasheim GM. Comparison of seven intravenous anaesthetic agents in man. *Brit J Anaesthesia* 1957; 29:194-209; total dose about 10.5 mg/kg in divided doses. These data show how just a 2-3x the usual clinical dose markedly increases the duration

Exhibit D

Figure 1

This schematic drawing shows how two drugs can have different durations of action. The brain concentration of the "short-acting" **red drug** is above the minimal brain concentration (**dashed blue line**) needed to produce the desired effect for a longer amount of time compared to that of the "ultrashort-acting" **green drug**. The onset times for the two drugs are the same.

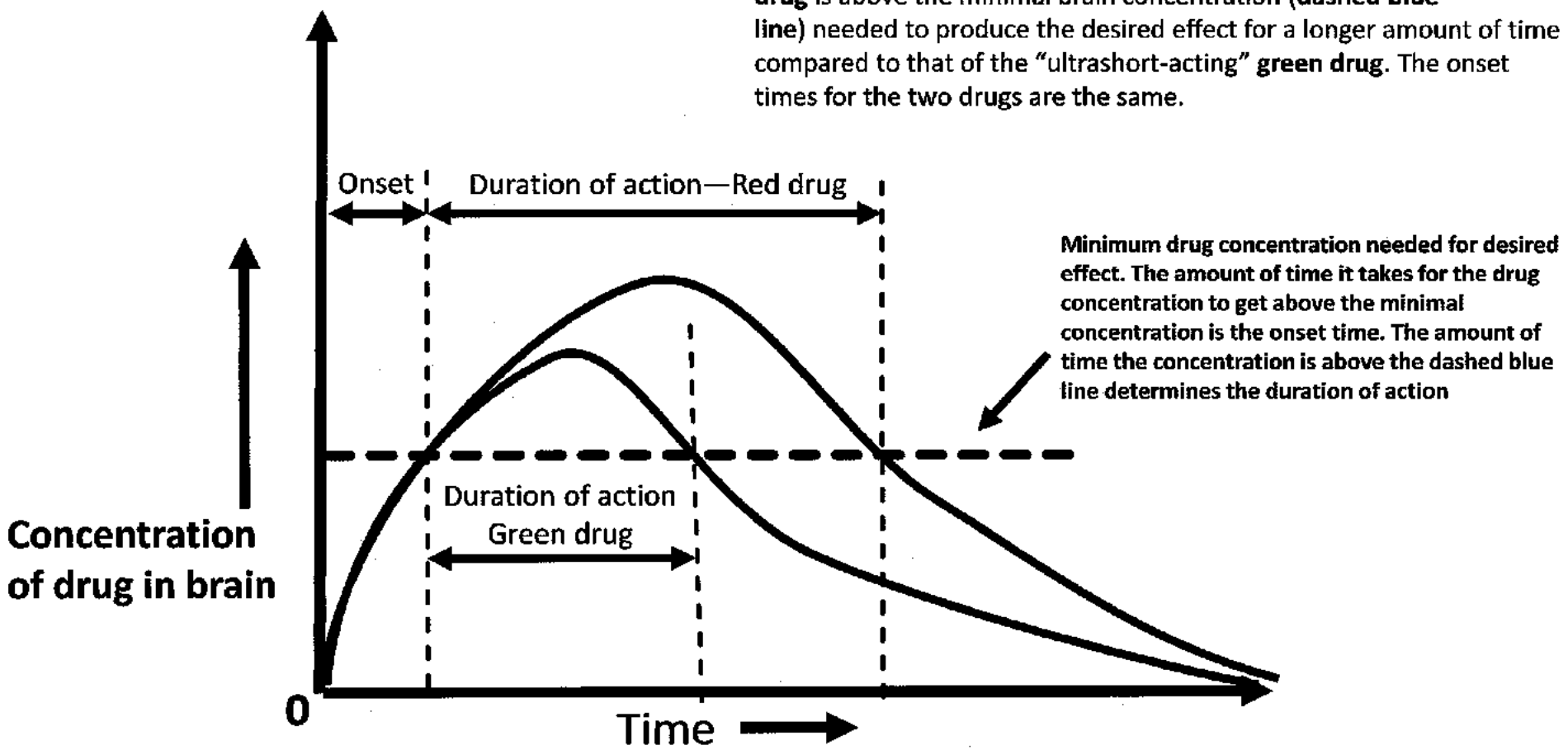
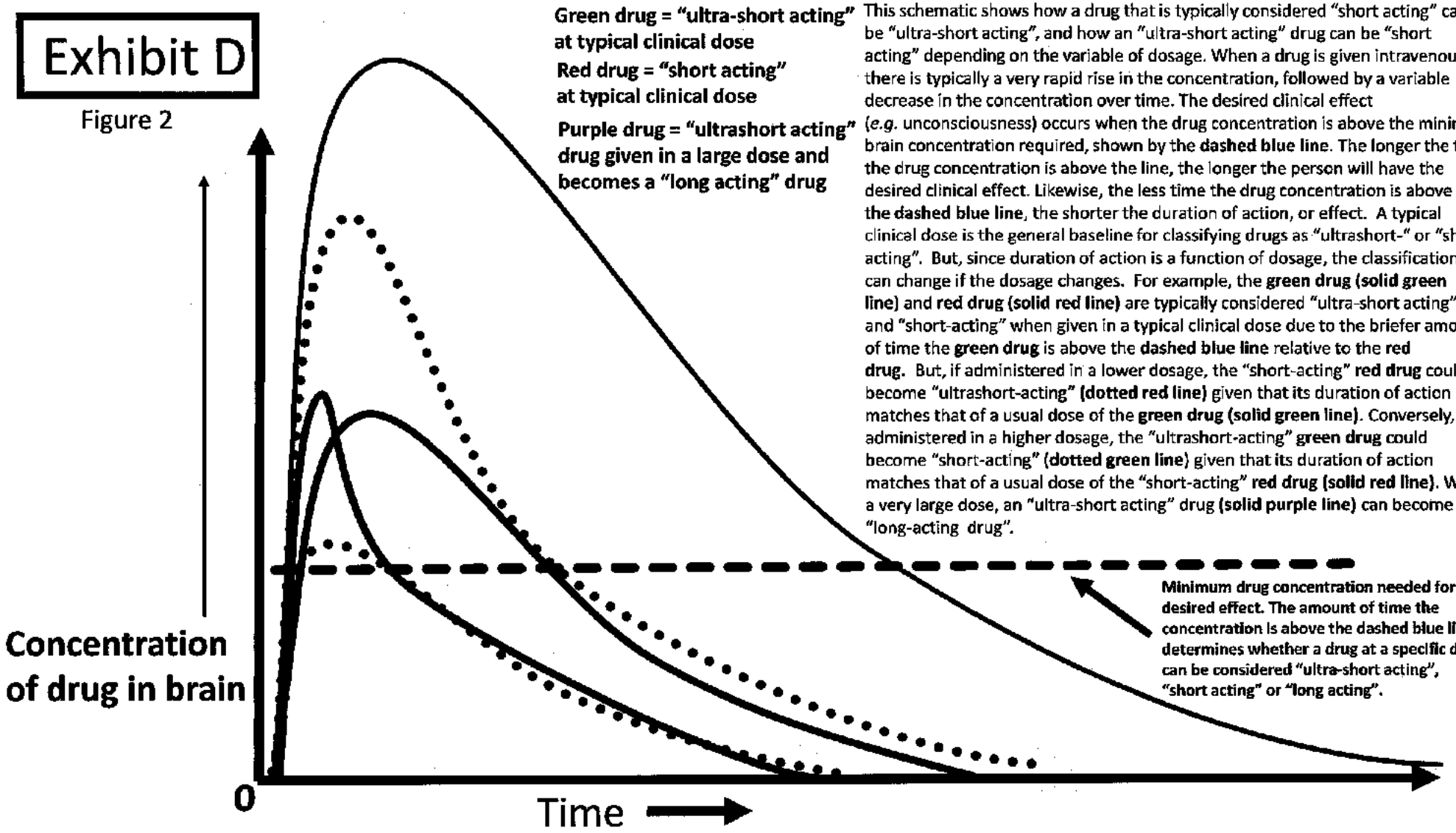


Exhibit D

Figure 2



This schematic shows how a drug that is typically considered "short acting" can be "ultra-short acting", and how an "ultra-short acting" drug can be "short acting" depending on the variable of dosage. When a drug is given intravenously, there is typically a very rapid rise in the concentration, followed by a variable decrease in the concentration over time. The desired clinical effect (*e.g.* unconsciousness) occurs when the drug concentration is above the minimal brain concentration required, shown by the **dashed blue line**. The longer the time the drug concentration is above the line, the longer the person will have the desired clinical effect. Likewise, the less time the drug concentration is above the **dashed blue line**, the shorter the duration of action, or effect. A typical clinical dose is the general baseline for classifying drugs as "ultrashort-" or "short-acting". But, since duration of action is a function of dosage, the classification can change if the dosage changes. For example, the **green drug (solid green line)** and **red drug (solid red line)** are typically considered "ultra-short acting" and "short-acting" when given in a typical clinical dose due to the briefer amount of time the **green drug** is above the **dashed blue line** relative to the **red drug**. But, if administered in a lower dosage, the "short-acting" **red drug** could become "ultrashort-acting" **(dotted red line)** given that its duration of action matches that of a usual dose of the **green drug (solid green line)**. Conversely, if administered in a higher dosage, the "ultrashort-acting" **green drug** could become "short-acting" **(dotted green line)** given that its duration of action matches that of a usual dose of the "short-acting" **red drug (solid red line)**. With a very large dose, an "ultra-short acting" drug **(solid purple line)** can become a "long-acting drug".

SUPREME COURT
STATE OF SOUTH DAKOTA
FILED

NOV - 1 2019

Clerk

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

CHARLES RUSSELL RHINES — Plaintiff and Appellant,

v.

SOUTH DAKOTA DEPARTMENT OF CORRECTIONS, MIKE LEIDHOLT, Secretary, South Dakota Department of Corrections, and DARIN YOUNG in his capacity as Warden of the South Dakota State Penitentiary — Defendant and Appellees.

App. No. _____
49CIV19-002940

Appeal from the Circuit Court, Second Judicial Circuit,
Minnehaha County, South Dakota

The Honorable Jon C. Sogn

APPELLANT'S REPLY BRIEF

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Mr. Rhines was not dilatory in seeking to enforce his statutory right to be executed according to the law in existence at the time of his conviction. To be clear, Mr. Rhines could not have brought the instant action to enforce his statutory right until the State informed him on October 17, 2019, that it would not comply with its statutory obligations. Unlike any prior litigation, Mr. Rhines is not challenging the protocol, only seeking to ensure that the State will follow the law as required by SDCL § 23A-27A-32.1 and SL 1984, ch 181, codified at SDCL § 23A-27A-32 (1984.).

Contrary to the State's Response, the Notice of Adoption of Revised Execution Policy and Protocol dated October 24, 2011 ("ERM"), put Mr. Rhines on notice that the DOC ***would*** comply with the law in effect in 1993 if Mr. Rhines so elected, not that it would disregard the statute's plain language. Notably, the State quotes a sentence from the ERM, but then omits the entirety of the sentence; the entirety actually supports Mr. Rhines's position. *Compare* State Resp. at 2 (arguing that the ERM "informed Rhines that if he elected the 2-drug protocol, he would be 'executed by the 2-drug protocol *set forth herein*.'") *with* ERM A.12(B).C1 (State's Exhibit 1 at page 3) (explaining that inmates sentenced to death before 2007 "shall be executed using the 3- or 1-Drug protocol provided in this document . . . unless the inmate requests in writing . . . that the inmate wishes to be executed by the 2-Drug protocol set forth herein *in accordance with South Dakota law as it existed* prior to July 1, 2007." (emphasis added)). The express language *imposes a limitation on* the protocol's application to ensure compliance with statutory law as it existed prior to July 2007, i.e., the 1984 statute in this case. Implementation of the 2-drug protocol "in accordance with South Dakota law" requires the DOC to use an ultra-short-acting barbiturate.

Thus, on the face of the ERM, Mr. Rhines had no reason to believe that, if he elected that option, the DOC would fail to comply with the South Dakota law as it existed prior to July 1, 2007, because (1) sodium thiopental was an option in the ERM and (2) the ERM stated that Defendants would follow the pre-2007 law.

There was no foreseeable, let alone ripe, issue regarding the State's use of pentobarbital until the State indicated, on October 17, 2019, that it would not comply with its statutory obligations—contrary to the ERM mandate that the State would not in fact act "in accordance with South Dakota law [in 1993]."

As it did below, the State continues to direct attention away from the issues before this Court. It relies on cases that have no bearing on the South Dakota statutes at issue or this Court's task in this case. For instance, the State relies on numerous Eighth-Amendment cases focused on whether an execution protocol likely will produce unnecessary suffering. *See, e.g.*, *Powell v. Thomas*, 641 F.3d 1255 (11th Cir. 2011); *Jackson v. Danberg*, 656 F.3d 157 (3d Cir. 2011); *Ferguson v. Florida State Prison*, 493 F. App'x 22 (11th Cir. Oct. 18, 2012). Other cases involve federal constitutional claims that have no bearing on how this Court reads and applies the plain language of its statutes, including one case that expressly noted that "'[a] violation of state law does not by itself constitute a violation of the Federal Constitution.'" *See Pavatt v. Jones*, 627 F.3d 1336, 1340 (10th Cir. 2010). This Court should not condone any violation of state law.

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CERTIFICATE OF COMPLIANCE

I, Timothy R. Rahn, hereby certify that the *Appellant's Reply Brief* in the above-entitled matter complies with the requirements set forth in SDCL § 15-26A-66. The *Appellant's Reply Brief* contains 892 words, 4,511 characters, and that said *Appellant's Reply Brief* does not exceed 16 pages and was typed in Times New Roman font, 12 point.

Ballard Spahr LLP

/s/ Timothy R. Rahn
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on November 1, 2019, two (2) true and correct copies of the foregoing *Motion for Stay of Execution* were served by prepaid U.S. Mail and electronic mail upon the following:

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